

Nursing Dept



The

MODERN HOSPITAL

Volume 44

APRIL, 1935

No. 4



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BROOKLYN

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For April, 1935

Just in Passing—

COVER PAGE—Gateway of St. Bartholomew's Hospital,
London, England

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ST. BARTHOLOMEW'S Hospital, London, the gateway of which appears on our cover this month, was founded in 1123 by Rahere, a man of humble birth and a court jester, in fulfillment of a vow and in obedience to the command of St. Bartholomew. Stricken by illness while on a pilgrimage to Rome, Rahere had a vision of St. Bartholomew, to whom he promised that he would found a hospital if the saint would cure him. He was cured. Rahere became an Augustinian priest and journeyed back to London and the spot which the saint had designated in the vision Rahere chose for St. Bartholomew's. He obtained the land by grant from the king. The next benefactor of St. Bartholomew's was old Dick Whittington, lord mayor of London and an opulent merchant besides. For more than eight hundred years, with one brief interruption in the reign of King Henry the Eighth, a devoted band of men and women have carried on their work of mercy in Rahere's hospital.

SOMEONE has been doing good publicity work for hospitals. Evidence: the editorial page of the March 16 issue of *Satevepost*. Under "The Plight of Our Hospitals" we read "None of our public institutions which look to the generosity of the public for their maintenance are feeling the pinch of depression more sharply than our hospitals. Many of them are compelled to operate upon a skeleton basis at a time when the demand for their services is most insistent." And so on for five well reasoned paragraphs. Marked reprints of the page might be available for local distribution if you write the editor.

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SP E A K I N G of publicity, an unusual but effective newspaper boost was recently given the Vassar Brothers' Hospital at Poughkeepsie, N. Y., by the local paper. A reporter in search of a story decided to interview the telephone operator at the hospital. And she proved to be a goldmine—from the reporter's point of view. After all a large part of the human interest activity of a hospital passes through its switchboard. If the telephone operator is the right kind of a person, she has a story that is good for a column in any local paper.

LAST month we promised two new features. On page 124 you will find the new department, "Hospital Literature in Abstract." Under the able guidance of Dr. E. M. Bluestone this department will bring you each month the essential gist of the most significant articles bearing on hospital administration that have appeared in foreign and American magazines. And in the expanded news section of this issue you will find some of the results of work by The MODERN HOSPITAL's state correspondents. The list of correspondents to date appears on page 102. They will be glad to have you send items of national interest to them.

TWO new series of articles are also starting in this issue. Dr. Herman N. Bundesen and his staff of the Chicago Board of Health are presenting a series on hospital plumbing hazards (page 71.) Amebic dysentery is only one of these. The other series will summarize the several hundred suggestions that have been made for distinguished service in hospitals. The first of four articles appears on page 63.

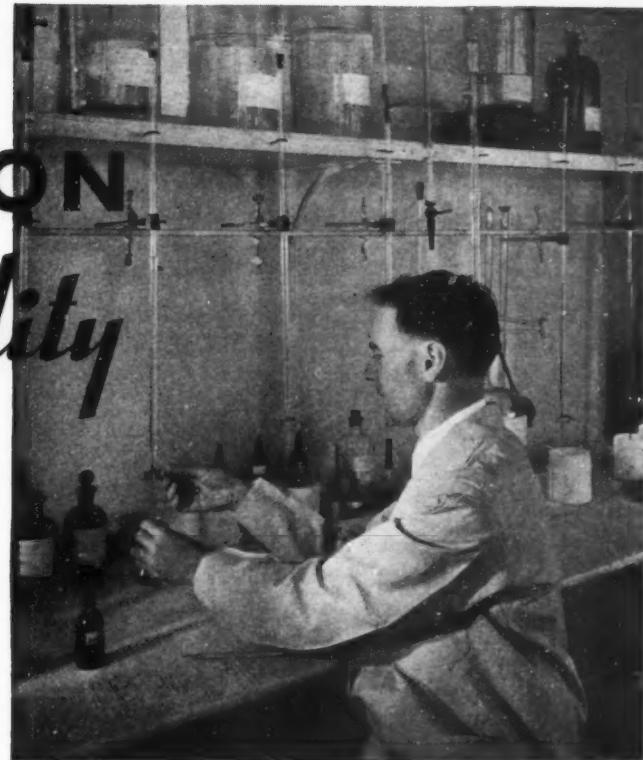
THE publishers regret that through oversight they permitted an advertisement to appear in the March issue which, by its language, reflected on other worthy products and in this respect was contrary to the

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HE INSISTED ON *absolute reliability*

IT WAS THE LACK of uniformity in medicinal products and anesthetic ether that caused Dr. E. R. Squibb to set up his laboratory and begin the work which proved so important and is today so well recognized. It is logical that, when he set out to perfect his process for the manufacture of ether, he should have insisted on raw materials of the highest quality.

Today the laboratories that bear his name are just as exacting—just as strict in the selection of the materials used in the production of ether. The sulphuric acid must be free from those volatile impurities which might find their way into the finished product. Very rigid specifications also govern the purity of the alcohol, for



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policies of the magazine. This instance of unfair advertising is mentioned here not because it is so common but because it is so unusual in the hospital field. Most of those who serve this field observe a professional attitude and confine their statements to the merits of their own products. Neither by direct statement nor by insinuation do they attempt to discredit the products or service of their competitors. Such a spirit should actuate all.

AS THIS issue goes to press word comes of the death of Dr. George W. Cale, Jr., of St. Louis, chief surgeon for the St. Louis Southwestern Railroad. Although Doctor Cale contributed notably to the advancement of American hospital service in St. Louis and the Southwest through his organization of a hospital system for the St. Louis and San Francisco Railway Co., he will perhaps be best remembered by hospital people because he introduced the late Frank E. Chapman into hospital administration.

FLASHES FROM THIS ISSUE:

"Many a hospital ward, floor or building is performing no useful service today because unforeseen economic changes have forced it out of line with current needs." *Page 49.*

"The recognized evils of fee splitting arise as readily between appliance maker or shoe dealer and physician as between physicians." *Page 62.*

"Experience in Chicago indicates that practically every water sterilizer of conventional type, except those manufactured or remodeled within the past few years, is so constructed that unsterilized water may enter the sterilized water tanks unknown to the hospital authorities." *Page 72.*

"Patients required to remain on bland or soft diets, as a direct result of this monotony in palatability and texture tend either to restrict their food intake below the amounts desirable or fail to adhere to the prescriptions." *Page 88.*

"In addition to doing its own work, the hospital conducts a commercial laundry service for the city and surrounding country." *Page 68.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.

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The Hospital Barometer

A seasonal rise in occupancy in both governmental and nongovernmental hospitals was recorded in February. Occupancy in both groups of hospitals was higher this year than in 1934 which in turn was higher than in 1933. This cumulative increase has brought the non-governmental hospitals closer to their 1930 total than at any time in last two years.

Hospital building projects reported from February 12 to March 11 numbered eighteen, of which fourteen reported costs totaling \$2,374,000. There was one alteration, one nurses' home, three new hospitals (all small) and thirteen additions to existing hospitals.

Business activity during February was well above the level of February, 1934, but receded somewhat toward the end of the month according to the weekly survey of current business by the U. S. Bureau of Foreign and Domestic Commerce. Uncertainty over the European situation, stimulated by Germany's announcement of her intention to re-arm, was an unfavorable business factor in March.

Averaged price changes were small in the latter part of February and the first three weeks of March. The index of the *New York Journal of Commerce*, which stood at 80.2 on February 16, declined to 78.4 on March 16. Grain prices fell during this period from 88.7 to 82.8, food from 81.3 to 79.9, textiles from 65.1 to 60.0, fuel from 81.3 to 78.7 and building materials from 92.1 to 91.9 (all indexes based on

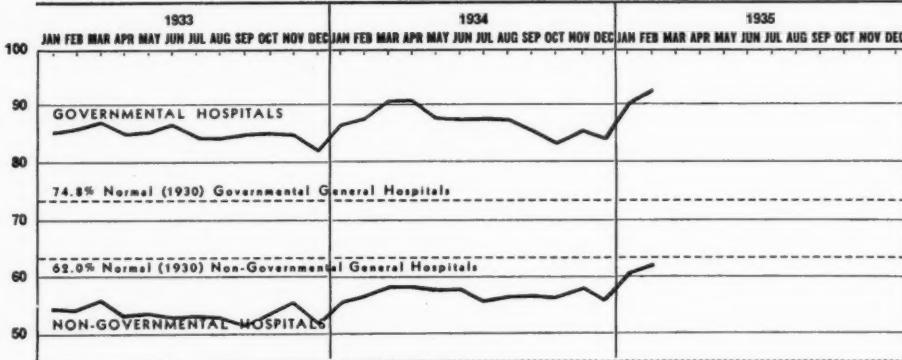
1927-1929=100). The figure of 80.2 for the general index, which was reached on February 16, was the highest point to which prices have advanced since September, 1930. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* advanced slightly during the early weeks of March but dropped back again to the February level late in the month.

The cost of living of industrial wage earners continued its upward trend from January to February, according to the National Industrial Conference Board. An increase of 1 per cent was due to sharp advances in food prices and rentals counterbalanced in part by declines in clothing prices. The cost of living in February was 5.2 per cent higher than a year ago but it was still 17.5 per cent lower than in February, 1929. On a 1923 basis, the purchasing power of the dollar was 121.4 cents in February as compared with 127.7 cents in February, 1934.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals ¹		1934												1935	
	Hospitals	Beds ²	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	
Nongovernmental																
New York City ³	68	15,194	70.0	73.0	75.0	75.0	75.0*	66.0	62.0	61.0	66.0	68.0	66.0	70.0	70.0*	
New Jersey	58	9,772	62.0	63.0	63.0	63.0	61.0	61.0	59.0	58.0	60.0	61.0	58.0	62.0	62.0*	
Washington, D. C.	9	1,776	65.0	67.2	65.8	62.8	62.8	58.4	59.3	60.7	65.4	65.3	61.8	72.0	71.8	
N. & S. Carolina	99	5,779	57.3	59.2	59.4	59.6	62.1	62.6	62.3	60.9	61.1	60.9	56.8	60.6	63.2	
New Orleans	7	1,196	43.4	46.5	42.1	43.2	48.4	43.3	52.1	49.5	49.5	47.7	44.9	47.7	50.6*	
San Francisco	15	2,825	63.0	61.9	61.6	60.3	58.1	56.8	56.9	60.8	64.2	63.2	62.0	65.5	65.5*	
St. Paul	6	912	53.8	49.4	50.7	47.3	49.1	44.9	45.7	43.4	39.1	45.8	45.8	41.5	53.6	
Chicago	22	5,866	53.5	53.3	55.4	56.5	57.7	57.3	59.3	55.6	56.9	57.9	54.5	57.4	57.5	
Cleveland	9	1,840	58.0	61.8	59.9	61.3	60.0	58.4	56.7	57.8	57.7	56.5	61.9	64.5		
Total ⁴	293	45,160	58.4	59.1	59.4	58.6	59.5*	56.8	57.2	56.3	57.7	58.6	56.3	59.8	62.1*	
Governmental																
New York City	16	11,615	100.0	105.0	103.7	101.9	93.7	91.3	89.5	88.3	89.4	91.0	92.9	96.7	100.6	
New Jersey	6	2,122	94.0	93.0	91.0	90.0	86.0	85.0	80.0	80.0	83.0	81.0	78.0	86.0	86.0*	
Washington, D. C.	2	1,076	88.3	83.2	84.3	84.7	84.7	79.0	80.2	81.7	78.1	84.8	77.6	86.6	95.5	
N. & S. Carolina	12	1,197	65.8	66.4	66.8	64.5	69.4	70.6	66.9	64.0	67.0	68.3	64.7	65.4	68.0	
New Orleans	2	2,227	112.5	129.5	136.4	127.1	137.9	148.5	152.4	148.0	129.3	131.6	130.5	144.9	145.4	
San Francisco	3	2,315	77.4	79.2	76.7	80.7	77.7	76.4	77.9	74.4	72.7	78.1	74.2	77.4	77.4*	
St. Paul	1	1,050	78.5	76.9	76.3	76.1	73.2	69.0	68.0	67.3	66.8	68.5	68.8	68.8*	78.7	
Chicago	2	3,790	94.3	93.2	94.6	91.1	87.5	84.8	83.7	83.1	84.8	87.0	84.7	89.0	83.4	
Total ⁴	44	25,392	88.8	90.8	91.2	89.5	88.8	88.1	87.3	85.9	83.9	86.3	83.9	89.4*	91.9*	

¹Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. ²Including bassinets, in most instances. ³Includes only general hospitals. ⁴The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.





HYLO INSTALLATION CUTS FUEL BUDGET IN MILITARY HOME

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REMOVES OLD COMPLAINTS

Erie, Pa.—How the Pennsylvania Soldiers' and Sailors' Home saved \$3,456.22 in the first two seasons after heating modernization is revealed in the three-year operating record kept by Col. David B. Simpson, Commandant.

During the 1931-32 season, the Home used 2,365 tons of coal. A survey was made to determine if heating modernization could reduce this expenditure and improve the heating service. After investigation, Webster engineers were confident that Webster Hylo Control would achieve both of these results. They produced records of savings in scores of similar buildings, many of them newer than the Soldiers' and Sailors' Home. Modernization was authorized and completed in the fall of 1932.

During the ensuing season, after making corrections for degree days, Col. Simpson reported the saving of 551 tons of coal, a 23.3 per cent reduction. With coal averaging \$2.90 a ton, this meant a reduction of \$1,597.90 in the '32-'33 heating budget.

The unusually severe '33-'34 winter, regarded as an acid test for the modernized system, saw a reduction of 534 tons from the '31-'32 figure. With coal retailing at \$3.48 a ton, this 22.6 per cent reduction meant a dollars and cents saving of \$1,858.32.

"In addition," Col. Simpson points out, "under the improved system we have cut our maintenance budget to negligible proportions. The elimination of freeze-up and leaking radiators means an annual saving, for plastering alone, of \$500 to \$600."

The Hylo Controls, installed in the Soldiers' and Sailors' Home, have been exceptionally effective where a number of buildings are heated from a central power plant. Steam can be circulated efficiently several thousand feet distant. A heating system for every need is assured by an entire group of Webster Systems of Steam Heating, which are equally effective in new buildings and in the modernization of outmoded equipment.

"We have constantly enjoyed real heating comfort, regardless of outside weather conditions," Col. Simpson said. "Our old heating complaints in various parts of the institution have been entirely eliminated. I personally feel that the money expended for this heating system modernization was the best investment we ever made."

If you are interested in (1) improved heating service and (2) lower heating cost in your building, address
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Branches in 60 principal U. S. Cities—Estab. 1888

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Webster
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 44

April, 1935

NUMBER 4

Group Practice of Medicine Succeeds in Rural Community

By W. G. SEXTON, M.D., F.A.C.S.

Marshfield Clinic, Marshfield, Wis.

EVERY Friday morning thirteen physicians come together for their weekly one-hour medical clinic in Marshfield, a community of 8,778 inhabitants in the center of Wisconsin's richest dairy country.

These men—two surgeons, three internists, three ophthalmologists and otolaryngologists, one urologist, one roentgenologist, two obstetricians and pediatricians, and one dermatologist—compose the staff of the Marshfield Clinic, which also employs four graduate nurses, four technicians and an office force of fourteen persons. One of the surgeons, who has had three years of expert training in pathology, acts as pathologist to the clinic and its affiliated hospital, St. Joseph's, owned by the Sisters of the Sorrows of Mother.

At each of these meetings two interesting cases, with résumés of the latest literature covering the subjects under consideration, are presented by

members of the staff, and a frank discussion ensues.

There is always abundant material for the cooperative study of this group, which holds a relationship of peculiar intimacy to the territory it serves. A special effort is made to obtain necropsies, which are thoroughly studied and recorded. Postmortems were performed on 30 per cent of those who died at the hospital last year. Physicians of neighboring towns are invited to attend evening meetings at

the hospital, and at these gatherings, which are held frequently during the year and have proved to be more popular and more valuable than the formal county society meetings, unusual problems in diagnosis and treatment are carefully explored.

Working as a group at the Marshfield Clinic we have tried to solve satisfactorily the social problem posed by the high cost of specialized technical services, while as individuals we have preserved the close relationship of gen-

A rural community of less than 9,000 inhabitants with a 170-bed hospital approved by the A. C. S., with thirteen physicians all of whom take postgraduate work in this country and ten of whom have studied in Europe is almost unheard of in rural medical practice. Such a situation exists in Marshfield, showing that distinguished service is as possible in a rural area as in a metropolis

eral practitioner and patient. We believe that one great factor in our success has been our control of the laboratories at both the clinic and the hospital. We use them without regard to cost, which could not be done if the hospital made an entry for each item. We seldom charge for these services, feeling that this work is essential to accurate diagnosis. To eliminate the very just criticism of the high cost of consultations with specialists, we all give our opinions freely on every complicated case.

A sympathetic public understanding of what we are trying to accomplish increases, we believe, our opportunity to give fruitful service, and we have thought it good to take an active part in the civic affairs of our community. We hold memberships in the Rotary and Commercial Clubs, and several

ice, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician."

It would be natural to assume, therefore, that this clinic is a recent outgrowth of the inspiration diffused by that report. The fact is, however, that the Marshfield Clinic was established in 1916 by Dr. Karl W. Doege and has been conducted ever since without deviation from the lines originally outlined by that clear thinking humanitarian.



The well stocked library at Marshfield Clinic where all standard medical journals are on file.

of our members have been appointed to the board of education, the library board and the park board.

For many years one member of our staff has acted as city health officer at a nominal fee. Whenever he has need of assistance in any major health problem he is assured of the wholehearted support of the entire group. As a community project we have cooperated with the school nurse in campaigns of preventive treatment, and have done vaccinations, Dick tests, Schick tests and inoculations of all the children in our schools, rendering these services at the lowest price in the state.

We believe that a visitor to our city would find that the Marshfield Clinic fulfills in essentials Recommendation I of the Committee on the Costs of Medical Care which reads as follows:

"The committee recommends that medical serv-

Doctor Doege, a profound student, was a frequent visitor in large American clinics and in surgical centers in Germany. From the time of his arrival in Marshfield in 1890 he generously shared his vast knowledge and experience with his colleagues and stimulated enthusiasm for advancement in diagnosis and treatment. For years he advocated the development of a medical group that could achieve outstanding results by cooperative work for the community, and in Marshfield, with exceptional railroad facilities from six directions, he believed he had found a suitable population center for the realization of his ideals. His undaunted enthusiasm, his staunch belief in his proposed plan, and his vigorous initiative surmounted all obstacles, and in 1916 he gathered six local physicians and incorporated them under the name of



St. Joseph's Hospital is affiliated with Marshfield Clinic. Here evening meetings are held frequently during the year and are attended by physicians from neighboring towns, who discuss unusual problems in diagnosis and treatment.

Marshfield Clinic. Another group of three physicians was organized shortly after this but joined the Marshfield Clinic within three years, leaving only three physicians to practice independently.

Almost twenty years ahead of his time, the ideas clearly formulated by Doctor Doege are now being recognized as the ideal outline of efficient medical practice. He believed that intimate association in our work, constant study and mutual assistance would gradually develop us along well defined lines to a relatively high standard of efficiency in our particular fields.

The prime consideration was to be the welfare of the patients, who were to be allowed absolute freedom in their choice of physicians. The intimate relationship of patient to physician was to be maintained at all times. The patient might be referred to others in the group for consultation,

operation or special treatment, but the selected physician was to follow through with unremitting attention every detail of the procedure. We were still to be general practitioners in the sense that we must be ready at all times to care for the needs of those who might require treatment in their homes in city or country.

This group arrangement would allow ample opportunity for postgraduate study and permit attendance at important medical meetings. Finally, a physician's salary was to be determined not by the actual amount of work done but rather by his contribution to the advancement of the clinic.

For the plan to be successful, it was essential that our hospital be rated in the Class A group. We had to have equipment to do all types of work, including x-ray, radium, metabolic studies, electrocardiograms, proper dietetics, and, above all, we



Marshfield Clinic's present building was erected in 1926 when the clinic had expanded and outgrown its quarters.

needed efficient laboratories under our control. This required a closed hospital staff. When we had reached these objectives real progress began.

Additions to the hospital have steadily increased its capacity. It now has 170 beds, including a separate isolation unit. In 1915 a training school for nurses was established and in 1922 a nurses' home was erected. Over several years the average number of students in training has been fifty-five. The school is rated as Class A and is affiliated with Ripon College. The hospital, approved by the American College of Surgeons, is accepted for internship by the American Medical Association, and two interns are now on duty there.

By 1926 the clinic had outgrown rented quarters and its present building, which is complete in every detail of modern equipment, was erected. We have

We are not equipped to do any special investigation or research but we feel that we have done some work that is worth while. One of our surgeons has a record of 209 cesarean sections with only two maternal deaths. We performed successfully the first resection of a unilateral fused kidney accomplished in America, and made a positive x-ray diagnosis of a phytobezoar prior to operation. We have developed rectal anesthesia and gas-oxygen analgesia to a high degree of efficiency in obstetrics. Our results in peroral endoscopy in both diagnosis and treatment, with the removal of over sixty foreign bodies from lungs and esophagus, have been most gratifying. We removed the largest mediastinal fibrosarcoma on record, with a span of seven years before recurrence.

For the past three years our average regis-



One of the clinical laboratories. Four technicians are on the staff.

at least two senior University of Wisconsin medical students with us for three months at a time throughout the year, our group having the approval of the University of Wisconsin Medical School by appointment to its extramural staff.

Three of our original members have died, but otherwise the association of our group has been continuous since the dates of joining the clinic, though there have been changes from time to time in salaried personnel. This association has resulted in those benefits of shared knowledge and opportunities for study that were foreseen by Doctor Doege. Ten of our group have taken postgraduate work in Europe. We hold memberships in state and national organizations and have representation at all important medical meetings, thus obtaining first-hand reports of new developments. We subscribe for all the standard medical journals, and in the excellent medical library that we use constantly for reference all books are catalogued.

tion at the clinic has been 27,000. The hospital cared for over 3,500 patients last year, with 1,700 operations. Our townsmen appreciate the fact that these people who come to our city for medical attention probably bring at least three or four times that number who do shopping here.

We have never attempted any flat rates for diagnostic work, but have endeavored to bring these services within the reach of all in our territory who need them. We realize that our overhead is greater than it would be if we were practicing as individuals, for, while we have eliminated much duplication of equipment we have added expense in more extensive records and more laboratory work. Yet none of us would be content to work under any other system.

Following the scheme laid out for us in 1916 by Doctor Doege, we believe we have demonstrated that adequate medical care can be obtained through group practice even in a small community.

Controlling Surgical Technique

By C. J. CUMMINGS

Superintendent, Tacoma General Hospital, Tacoma, Wash.

THE surgical staff of the Tacoma General Hospital, Tacoma, Wash., is divided into three groups with the following ratings, senior major surgeons, junior major surgeons and minor surgeons. There are also major surgeons in specialties, who may perform any operation in their field.

The classification began in this way. In February, 1921, the staff advisory committee of the hospital made a report to the board of trustees recommending that the hospital adopt the plan drawn up by the American College of Surgeons to promote a high standard of scientific work and to establish minimum standards for the work of surgeons in hospitals. The committee recommended to the board that the following rules be enforced:

1. The data required for efficient case records shall be recorded upon case history records, as provided by the Tacoma General Hospital, by the attending physician or surgeon or his representative, but refusal or neglect on the part of the attending physician to record and give the necessary aid to the medical statistician in the recording of data shall terminate his privilege of treating cases in the hospital.

2. In surgical cases the essential history pertaining to the condition for which the patient is to be operated upon, together with the record of the physical examination, must be furnished to the hospital before the patient is operated on, except that in emergency cases this history may be dictated by the surgeon before or during the operation. In nonemergency operative cases the history and record of the physical examination shall be delivered to the hospital by the surgeon, or ample time shall be allowed for taking the history of surgical patients after the patient reaches the hospital.

3. In all surgical cases the surgeon shall, previous to operation, record the diagnosis on the

history on which his treatment is based. This diagnosis shall be posted on the board where operations are listed.

4. During or at the close of each operation a description of the pathologic findings and of the operation shall be recorded, together with a diagnosis based on the gross pathology. This shall be dictated by the surgeon himself.

After the recommendations of the staff advisory committee were ratified by the board of trustees, an invitation was sent out on March 29, 1921, to the doctors on the hospital staff to meet and discuss the best means of standardizing the surgeons in accordance with the requirements of the American College of Surgeons. A committee of three was appointed to list those doctors who were doing major and minor surgery according to their ability. At the same time, the chairman of the staff advisory committee was instructed to write to the college to ascertain the legal status of the hospital in regard to the matter of refusing the surgeons the privilege of operating.

According to Dr. Franklin H. Martin, director general of the college, in order to correct inferior work or eliminate an objectionable staff member, it is necessary to keep accurate clinical records and pathologic specimens as evidence of the type of scientific work done in the institution. There should be a critical review of clinical records by a proper committee of the medical staff over a sufficient period of time so

as to establish justifiable conclusions as to the quality of the clinical work. There should be frank, fearless discussion of the clinical work at staff conferences so as to create an environmental influence on all of the members and bring out any irregularities in practice which might be subject to criticism.

If irregularities exist, the superintendent should have a conference with the offending member or members calling attention to any criticisms re-

garding the work in an endeavor to rectify such conditions. If the superintendent fails to accomplish the above with the staff member in question, the matter should be taken to the executive staff and the offending member given another opportunity for defense. If it is not settled in the above manner, the matter should be brought before the entire staff for discussion, again giving the accused an opportunity for defense. The next step should be to present to the board of trustees or governing body all of the data available and such recommendations as are deemed advisable. If any action is taken which involves suspension, dismissal or discipline, this should be exercised by the board of trustees through the superintendent and not by the medical staff. Doctor Martin's plan was adopted as a policy of the hospital.

The surgical committee made a survey of the results of surgery to determine the ability of surgeons individually and as a class. It was concluded to be generally satisfactory. Under this plan certain doctors have been reduced in surgical rating, but most of the staff doctors have qualified for advancement.

In April, 1921, a list was prepared showing the three grades of surgeons. The staff advisory committee defined each of these groups and their advice was accepted by the hospital. They prepared a list of doctors with the recommendation that any doctor whose name did not appear on the list and, who requested permission to operate in the hospital should be referred to the superintendent. In order to determine what procedures might be carried out by men in the various groups, the operations were divided into minor and major procedures as nearly as possible and any questionable procedure was to be referred to the chairman of the surgical committee for decision.

Senior Major Surgeons Unrestricted

Senior major surgeons have the full sanction of the hospital to operate on any surgical cases within their field. This group is unrestricted as to procedure. It is deemed that a member of this group will have had sufficient experience to ask for special assistance should this be required. Out of town surgeons who are fellows of the American College of Surgeons are given the same privileges as accredited senior major surgeons, so that they need not have an accredited major surgeon on the case with them. The accompanying list shows surgical work for which members of the groups may be responsible.

The classification of surgeons is open at all times to revision. It is the policy to advance surgeons from lower to higher groups just as rapidly as their increasing skill and efficiency may justify. Ob-

CLASSIFICATION OF SURGICAL WORK	
<i>Senior Major Surgeon Only</i>	Empyema with rib resection Perineorrhaphy — except cases involving rectal sphincter Bunion Trachelorrhaphy Curettage of uterus Varicose veins Varicocele Hydrocele Epididymotomy Epididymectomy Vasectomy Orchiectomy Hemorrhoids Anal fissure Plastic work Inguinal hernia Appendicitis — nonruptured
	<i>Junior Major Surgeon After Consultation With Senior Major Surgeon</i>
	Benign tumors of breast Umbilical hernia Epigastric hernia Uterine suspension Salpingectomy Ovarian cyst Cystocele
	<i>Minor Surgeon</i>
	Scalp wounds and head lacerations Tonsils and adenoids Peritonillar abscess Diagnostic biopsy Circumcision Amputation of fingers and toes Tendon and nerve suture —emergency Skin graft Blood transfusion All superficial lacerations Ingrown toe nails Felon Sebaceous cysts Ganglion of hands
	Abscess of breast Tracheotomy

versely, an inferior quality of work on the part of a surgeon in either of the higher classifications is considered as sufficient reason for lowering his rating.

When a surgeon is assigned to one of these ratings, the superintendent sends him the following form:

"At a recent meeting of the staff advisory committee it was advised that your name be placed in the classification of _____. I trust that this decision will be satisfactory to you and confidently hope that you will understand that it is my sincere desire and that of the senior surgeons to help you in any way possible to advance to a higher group."

A committee of doctors was appointed by the staff advisory committee to draft a report on the qualifications of a major surgeon. "In our opinion,"

the committee said, "there are two outstanding qualifications, the proof of which the applicant for major surgical classification should submit—(1) proof of his moral stamina; (2) proof of sufficient technical and diagnostic ability. Of his moral stamina we can only suggest that he be the type of man of whom we can all say that he is ethical in every sense of the word. If the respective surgical boards are to be judges of this requirement, it stands to reason that the boards in themselves must be fair-minded, unprejudiced, open and above board in their investigations. No petty jealousies, no personal likes or dislikes should befog their decisions.

"Regarding the applicant's proof of sufficient surgical and technical ability, we suggest: (a) that the standard of the American College of Surgeons for their membership be also required by the respective surgical boards of our hospitals, with this exception—that the number of case records submitted by the applicant shall be one-half of that required by the American College of Surgeons; (b) that the cases recorded and submitted shall have been performed by the applicant under the supervision of a major surgeon; (c) that each applicant shall have had at least one year of internship in a Class A hospital, and shall have worked for at least two years with a major surgeon as an assistant after his internship. Also, he shall give evidence of serious effort to improve his surgical knowledge and skill by visiting local and other surgical clinics and medical meetings."

In May, 1929, when Dr. Malcolm T. MacEachern, director of hospital activities, the American College of Surgeons, made an annual tour of inspection of various hospitals, he visited the Tacoma General Hospital. In his speech before the medical staff, Doctor MacEachern said that in analyzing the qualifications that should secure a place on the staff for a doctor, four points should be considered—first, ethics; second, competence, and this means largely a knowledge of one's own limitations; third, loyalty to the hospital; fourth, patronage.

How Promotion Is Determined

Therefore, when he has assisted in twenty-five cases of major surgery and himself operated on twenty-five cases under the supervision of a senior major surgeon, who is scrubbed as first assistant, a junior major surgeon may file complete records of cases done and assisted, with a request for advancement to a higher rating. Advancement is determined by a committee of three major surgeons of the senior group, appointed by the chairman of the staff advisory committee. At least one of these must be a member of the staff advisory committee. The duty of this committee is to re-

view the history and records in their entirety as to correctness of diagnosis, treatment and final result. Due consideration is given to preliminary training, surgical judgment and experience, outside of mere ability to carry out technique. Observation of the applicant at work is essential, if practical, and the applicant is expected to cooperate to this end. The case records which the applicant submits should be as varied as possible. The staff advisory committee is empowered to act finally on the recommendations of the examining committee and the approval of the hospital.

At first the requirements were fifty major operations at which the applicant was first assistant, and fifty major operations performed by the applicant himself, but at the present time, twenty-five each are required.

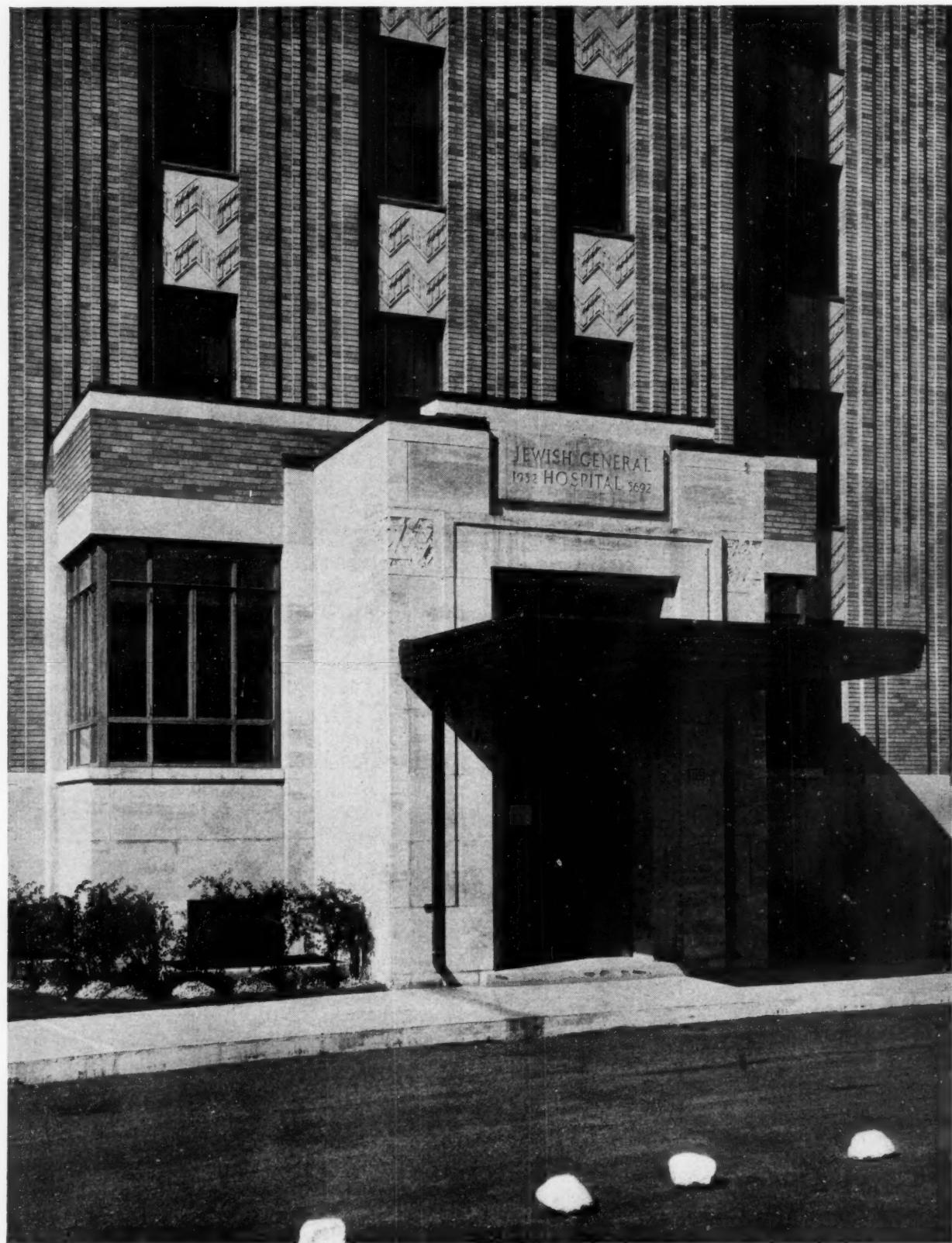
Requirements for Major Rating

The applicants for major surgical rating must fill out an approved application blank, one part of which was formulated by the surgical committee. It requests the following data: (1) school and date of graduation and degrees, (2) hospital experience, (3) any additional experience, (4) presentation of the following number of cases, either in the original or certified copies—twenty-five major cases which have been operated upon and cared for by the applicant in every detail, that is, he must furnish a report of the complete history, physical findings, laboratory work, preoperative and post-operative diagnoses, operative procedure, findings and final result. He must also present twenty-five cases in which he has served as first assistant. A synopsis of these cases is acceptable.

Although the requirements demand only twenty-five cases each, there are many surgeons who still perform fifty cases each before submitting a request for advancement to a rating higher than that under which they are classified.

After the examining committee has reviewed the application and the report, the applicant is notified as to his acceptance or he is given recommendations as to what steps are necessary to comply with the requirements.

In January, 1933, the late Dr. C. W. Moots made a tour of inspection for the American College of Surgeons. He suggested that standardization of surgeons' technique might be a way of reducing costs of medical care, and that the attending men should support the interns and both should collaborate in writing the histories in a sequence of events. When the working diagnosis agrees with the final diagnosis in over 60 per cent of the cases, it is evident that the history was written after the final diagnosis was arrived at, and not in sequence as it should be.



The exterior of the building has been treated in modern manner without cornices or moldings, relief being obtained by simple breaks in the brickwork and the use of metal spandrels. The entrance projects on the street and the hall windows occur on the corners of this projection. The structure is of reenforced concrete backed with terra cotta.



Rearrangement of Space Possible at New Jewish Hospital

By J. CECIL McDougall, C. DAVIS GOODMAN and S. S. GOLDWATER, M.D.
Architect and Associate Architect, Montreal, and Consultant, New York City, Respectively

THE Jewish General Hospital of Montreal, Que., which opened on October 9, 1934, is not a hit-or-miss affair but is the product of careful planning by a building committee conscious of its responsibilities, eager to satisfy the reasonable requirements of all classes of patients, determined to avoid extravagance, and alive to the danger of embarrassing the administration of a hospital by offering for its use a structure not readily adaptable to changing demands.

Many a hospital ward, floor or building is performing no useful service today because unforeseen economic changes have forced it out of line with current needs. In the new Jewish Hospital patients' accommodations are of such a character as to render social and clinical reclassification practicable from time to time at little or no expense. In the public ward section, no room contains more than four beds. Wards of this kind, properly related to each other and to the supporting services, can be utilized for the accommodation of free or

part-free patients, without undue expense. On the other hand, curtained beds in wards of this description, tastefully furnished, are also available for patients of moderate income.

In the semiprivate division, to which the building program assigned the third floor, typical two-bed rooms measure approximately 10 feet 6 inches by 15 feet 6 inches (a few of the rooms are longer) and any of these can be converted into single private rooms if the public demand should require this. There would be no difficulty about combining a pair of these rooms into a four-bed ward if future demand necessitated a more extensive public ward service than the original plans contemplate.

When the planning of the hospital was undertaken, certain limits of expenditure were set, and the bed capacity of the proposed hospital was fixed by the building committee. The first care of the committee was to choose a suitable site. After a survey of the city, a site was chosen at the very edge of the settled portion of Montreal, in a dis-

trict where suitable sites were still purchasable at nonprohibitive prices.

The site chosen runs approximately east and west for a distance of over 1,000 feet, along the new extension of Cote St. Catherine Road. Advantage was taken of the fact that the ground falls off towards the north in such a way as to minimize the cost of excavation and provide level entrances at the front of the building for both in-patients and out-patients, with an entrance at a lower level in the rear for ambulance and delivery service.

Abundant "Sun" Space Provided

At the east and west extremities of the T-shaped hospital building solariums glazed with ultra-violet-ray transmitting glass were introduced. At one end the first floor was extended to accommodate the out-patient department. The roof of this extension is at the ward floor level and is available as a sun deck for ward patients. Other open decks are available on the fifth floor, above the solariums, and on the roof of the main structure at the sixth floor level. From all of these outdoor spaces, and especially from the solarium and roof spaces on the sixth floor level, a magnificent view of the surrounding country is afforded.

The first or main floor of the hospital building is functionally divided into three distinct parts. To the left of the main entrance is a corridor flanked by the administrative offices; at the end of the corridor is a large lecture room for meetings and staff conferences; to the right of the main entrance hall is the out-patient department.

In the rear wing the principal diagnostic and therapeutic auxiliary departments have been assigned to include the x-ray department, cystoscopic room with x-ray equipment, metabolism room, the general laboratory, equipped for pathology, bacteriology, chemistry and clinical pathology and the department of physiotherapy. At the junction of the out-patient department and the sec-

tion containing these special departments are rooms for surgical out-patient work and a minor operating room, with direct elevator service from the ambulance entrance just below. Patients assigned to the x-ray or laboratory departments from the out-patient department have no long distance to go, and the placing of the elevators facilitates service between the ward and private patients' floors and the laboratory and x-ray departments.

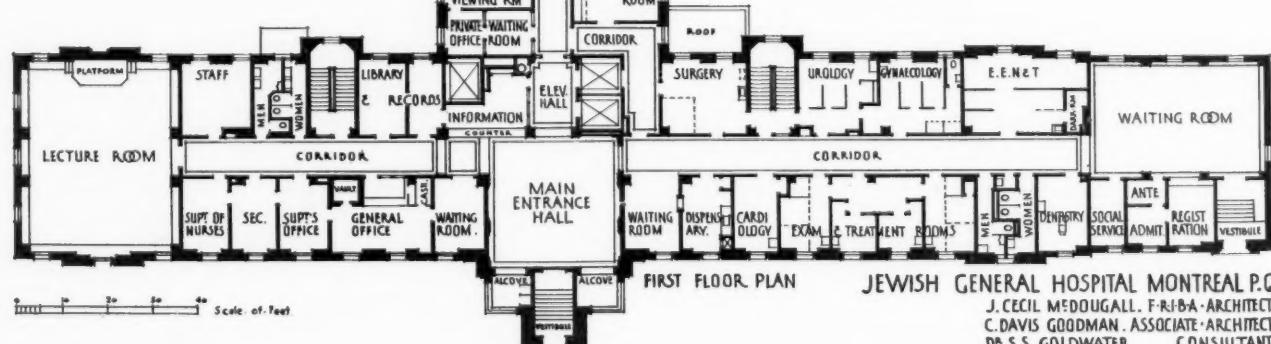
The accompanying first-floor plan shows a commodious waiting room for the out-patient department, with registration room, admitting office and social service room adjoining. By assigning to ward visitors those hours which do not conflict with the hours of dispensary service, it will be possible to use the out-patient waiting room as a waiting room for ward visitors.

The out-patient department program called for separate quarters for the eye, ear, nose and throat service, and for gynecology, urology, surgery, dentistry, cardiology and medicine. The most extensive series of connected rooms is assigned to medicine, which has five intercommunicating rooms, two of which are large enough to contain two examining tables in curtained cubicles. Other clinical departments, such as pediatrics, which require approximately the same accommodations and equipment, will use the examining rooms of the department of medicine at assigned hours.

A separate waiting alcove adjoins the drug dispensary. On the ground floor, immediately below the main waiting room of the out-patient department, is a well lighted space which can be utilized in the future for an expanded dispensary service.

There are two rear entrances to the ground floor. One of these is for supplies, the other for the reception of ambulance patients. On one side of the ambulance entrance is a detention room, and on the other an elevator which connects with the emergency treatment room on the floor above, as well as with all of the patients' floors and the operating and delivery rooms.

The kitchens occupy the entire rear wing and are arranged in conformity with the spe-



cial demands of the Jewish dietary laws. The kitchen equipment is arranged in logical order. An extensive space for carts and the setting-up of trays immediately adjoins the food service elevator, which communicates with centrally located serving kitchens on the patients' floors.

Dining rooms for officers, staff, interns and nurses are grouped around a commodious serving room. A separate serving room arranged for cafeteria service is provided for the help. For the most part, the hospital help will be nonresident; several rooms have, however, been provided on the ground floor for resident orderlies.

Directly beneath the drug dispensary room, and having a dumb-waiter connection with it, are work and storage rooms for the department of pharmacy. The general supply room immediately adjoins the goods receiving lobby. Opening off this lobby is a large sized freight lift which descends to the basement floor where extensive storage space is available for bulk merchandise. The necropsy room and its accessory services are placed at the basement level where privacy is assured.

The pitch of the land is such that the rear wing emerges above the ground at the basement level and this well lighted section has been assigned to the laundry. Other well lighted sections of the subbasement will be utilized for workshops, mechanical supplies, mattress storage, storage of patients' clothes and other similar purposes. The freight elevator service is convenient to all departments.

The second floor has been designed primarily for ward patients. At the junction of the stem and arms of the T-shaped floor are two full sized passenger elevators. Directly facing these is a central control station. Opposite the elevator lobby is a visitors' waiting room. About this center the patients are distributed in three groups — men, women and children. The length of the main block is 235 feet; its width, except at the expanded center, is 45 feet. The rear wing has a length of 75 and a width of 50 feet.

In the rear wing there are twenty-two beds for children, divided into

three six-bed wards, each ward subdivided into individual cubicles, and four one-bed wards. The children's service is self-contained as to ward kitchens, utility rooms, bath, toilet, treatment rooms, and linen supply.

For adult patients there are forty-six beds; forty distributed among ten four-bed wards, and the remaining six in two-bed and one-bed rooms. There is running water in each of the wards. The adult patients' section is planned for men and women. Nurses' station, sink room, bath and toilets are provided in duplicate, and advantageously located.

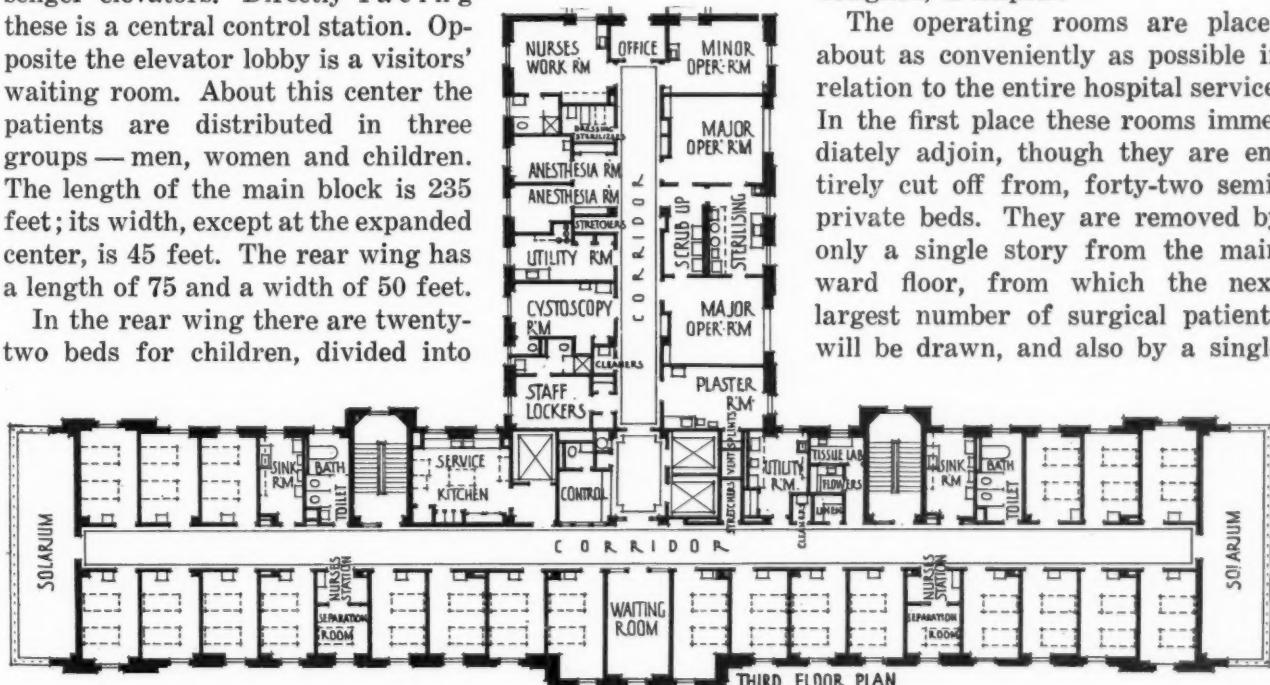
Kitchen Entrance Strategically Placed

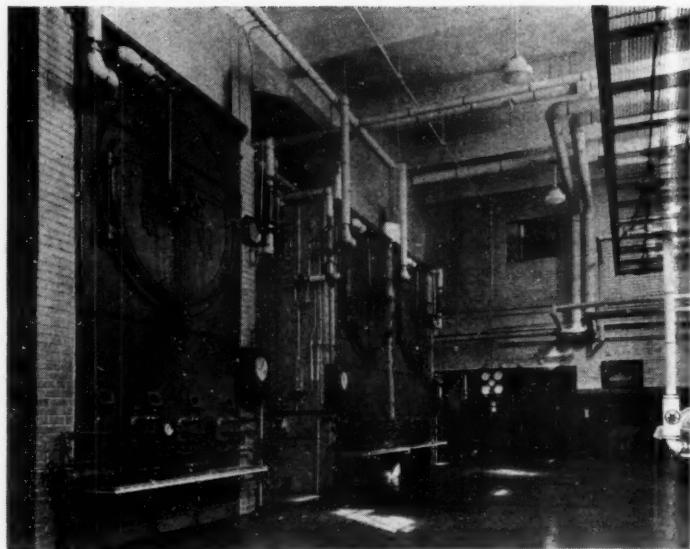
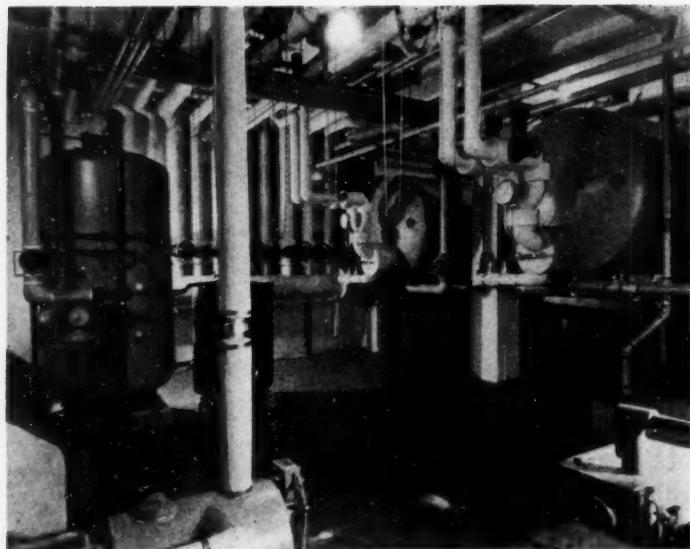
A single centrally located serving kitchen supplies both ends of the building. The entrance to this kitchen is through an elevator lobby which aids in noise control. Adjoining the passenger elevators are a stretcher closet, a linen closet, a central workroom with sterilizing equipment and blanket warmer and a combination ward laboratory and examining room.

A telephone booth for visitors and patients opens off the elevator lobby. Connected with the central control station, facing the passenger elevators, is a nurses' retiring room.

On the third floor, planned as a semiprivate patients' floor, two-bed rooms prevail, and each room has a lavatory. The distribution of nurses' stations and utilities follows in essentials the ward floor arrangement. The semiprivate floor has a total capacity of forty-two beds. As a majority of these are likely to be surgical cases, the proximity of the operating rooms, to which, with their accessories, the rear wing of this story has been assigned, is helpful.

The operating rooms are placed about as conveniently as possible in relation to the entire hospital service. In the first place these rooms immediately adjoin, though they are entirely cut off from, forty-two semiprivate beds. They are removed by only a single story from the main ward floor, from which the next largest number of surgical patients will be drawn, and also by a single





The tank room (left) is in the basement of the main building and contains three hot water service heaters. The boilers are in a separate boiler house (right) connected to the main building by a tunnel which also contains the connecting piping.

story from the fourth floor from which the third group of surgical patients, the private patient group, will come. The arrangement of the operating rooms is shown in the plan on page 51.

The distribution of single or private rooms on the fourth floor is pretty much the same as the distribution of semiprivate rooms on the third, except that the two subsidiary nurses' stations have been dispensed with. A commodious central nurses' station adjoining the passenger elevator lobby has been retained.

Three of the largest rooms on this floor at the center of the building are available for either single or double occupancy. Adjoining the elevator lobby at the focal point are a nurses' rest room, an examining and treatment room and a visitors' waiting room. With a view to noise control, these rooms are cut off by corridor doors from the patients' corridor. On the private patients' floor, as on the floors below, the service kitchen is likewise cut off from the central corridor by an entrance lobby. The two sink rooms, so placed as to minimize the distance from patients' rooms, are entered through short side corridors and are reasonably remote from the main corridor.

Few Private Baths Included

The luxury of innumerable private toilets and baths, which is so common in many modern hospital structures and which has been the subject of a good deal of criticism on the part of hospital and social economists, was not practiced in the planning of the private patients' floor. Of the twenty-five patients' rooms on this floor, only four are provided with individual toilets and two with individual private baths. Whatever might have been the personal opinions of the designers of the build-

ing, the limitations of the building fund settled the matter. A flower closet, which for the sake of economy was omitted from the ward floor, was thought indispensable on the private and semi-private floors.

In the rear extension on the fourth floor, two single bedrooms with connecting bath have been set aside for residents, and four double rooms with congregate bath and toilets, for interns. The interns have also at the extreme end of the building far removed from any patient's room, a sitting and recreation room. The location and arrangement of the interns' rooms are such as to make them easily convertible into patients' rooms. From six to twelve additional private or semiprivate patients can be accommodated in this section whenever the need arises, or the space could be assigned to a specialized ward service without lessening the attractiveness of the original private patients' floor.

Bearing in mind the maternity department's need of strict segregation, the fifth floor of the building has been reserved entirely for this service. In a building extending three ways from the central elevator lobby, it has been possible to make a suitable classification of ward and private service. In the rear wing there are four wards with a total capacity of sixteen beds for ward patients. This unit has its own nurses' station, sink room, toilets, shower, and crèche.

Adjoining the central elevator lobby are a control station for the entire floor, a "brith" room, a waiting room for visitors, and toilet accommodation for male visitors. Private and semiprivate maternity patients' rooms occupy half of the main stem of the building. The crèche for private and semi-private patients is opposite the central utility room,

and there are no patients' rooms in its immediate proximity. At the easterly end are delivery and labor rooms, entirely cut off from the rest of the floor. There is also a self-contained isolation suite for infected cases.

A solarium, thirty-two feet in length, with south, east and west exposure and ample roof space adjoining, occupies the sixth floor.

The exterior of the building has been treated in a more or less modern manner without cornices or moldings, relief being obtained by simple breaks in the brickwork and the use of metal spandrels. The small units which compose the interior are distinctly expressed and a vertical feeling imparted to the composition by the introduction of fluted piers between windows.

The main entrance forms the only decided projection on the street front and is distinctive in that the entrance hall windows occur on the corners of this projection, the masonry above being cantilevered to provide as much window area as possible. This treatment is successful both from the outside and from the entrance hall.

The solarium at the roof level and the elevator penthouses rise above the main building, forming a central group which, flanked by the stair towers, dominates the whole mass. The large solariums at each end are also prominent features with their unobstructed expanse of steel sash and glass.

The rear wing and elevations follow the lines of the front with the result that the building viewed

from any angle presents a distinctly homogeneous appearance. The structure of the building is reinforced concrete, backed with terra cotta and faced with a light buff brick generally. The lower portion of the building up to the level of the first floor window sills is in limestone, as are the string courses and copings.

The main entrance vestibule and hall are finished in travertine and black and gold marble, the latter having an ornamental rubber tile floor with the hospital "device" in the center. The corridors have linoleum floors and acoustic plaster ceilings to reduce noise to a minimum. Pleasingly varied color schemes have been used in the different wards.

Boiler House Connected by Tunnel

The building is heated by means of a vacuum system of steam heating with direct radiators in all the various rooms. The radiators in most of the important rooms and the four-bed wards are controlled by means of unit thermostatically controlled valves located directly under the radiators.

Steam for the heating system, sterilizers, laundry and kitchen is generated in three oil fired horizontal tubular boilers of 160 h.p. each. The boilers are in a separate boiler house connected to the main building by means of a tunnel which also contains the connecting piping. The boiler house contains an oil fired incinerator, switchboard room, transformer room, garbage room, toilet, engineer's storeroom, also an animal room and office.



The entrance vestibule is finished in marble, with an ornamental rubber tile floor having the hospital "device" in the center.

A tank room is in the basement of the main building and contains three hot water service heaters, two vacuum pumps for the heating system, water softener and two return pumps and receiver for returning all the condensation to the hot well in the boiler house. Two of the hot water heaters are for the domestic hot water supply and one for the kitchen and laundry, which is run at a higher temperature.

Sterilizer rooms, sink rooms, utility rooms, interior toilets, kitchens, toilets and the laundry are ventilated by means of exhaust ventilation with a separate fan located in the penthouse on the roof. Fresh air is also supplied to the kitchen by means of unit ventilators.

The electric power supply is obtained from the local power company and is delivered at 4,000 volts, four wires, and three phases. There is a duplicate incoming service controlled by two mechanically interlocked oil switches. The transformer room is in the power house and contains the transformer banks to reduce the voltage for different purposes.

Although there are two incoming supply lines it was considered necessary to have absolute reliability of power supply in certain parts of the hospital and so a small steam turbine generator set was installed to carry the lighting of all corridors, stairways, operating rooms, the power house, certain pumps and one elevator.

The signaling consists of a nurses' calling system and a flashing type doctors' paging system.

The hospital has accommodations for 176 patients and the contract for the work was signed on August 31, 1931, the building being completed a little over a year later on December 1, 1932.

The original contract amounted to the sum of \$761,325.87 but during the progress of the work a reduction was made of \$21,717.06 or a saving of 2.85 per cent.

The total cubage of the work on completion, including the power house, was 1,402,650 cubic feet. The cost per cubic foot exclusive of fees was 52 cents, and the cost per bed \$4,413.

An Architect Evaluates the Plan

Albert Kahn, Detroit architect, sums up his views on the design of this hospital in the following paragraphs.

The general plan of the Jewish General Hospital appears to me clearly thought out and exceptionally practical. The various divisions are not only well arranged but splendidly coordinated. The plan is so straightforward as to afford both economical construction and maintenance.

In certain minor details one may take issue with the designers. It would have been better perhaps

if the library and record room adjoined the general office, changing places with the superintendent's offices. Then the rear wing provides no direct means of communication between stories. This means that either the elevators must be used or one of the stairways in the main building must be sought. Incidentally, considerable elevator service would be saved if one stairway were accessible from the elevator lobby.

It is pleasant to see a central visitors' waiting room provided on the patients' floors which too often is forgotten. Toilets for men and women visitors would be desirable.

Finds Plan Well Coordinated

With only the first and third floor plans published, a review of the other floors is impossible. However, it is obvious that here we have a plan which is the result of proper cooperation between the architect and the hospital staff, and consultation with an outstanding expert. All are to be congratulated on the fine solution of the problem that has been worked out.

As for the exterior, the chances are that the reproductions fail to do justice to the building. The main entrance feature seems to me rather unhappy and the handling of the vertical piers fussy. While the exterior is on the whole straightforward, I should have preferred an even simpler treatment. Architecture as a rule suffers more from overdoing than from the opposite.

Facts About Hospital Psychiatric Departments

The plan of affiliating a psychiatric department with a general hospital meets with favor among those who have tried such an arrangement, according to a survey by Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., which is reported in the thirteenth edition of *The HOSPITAL YEARBOOK*. "It is significant that there was no dissenting voice, as most of the questionnaires were answered by the psychiatrist rather than the superintendent," Doctor Munger states.

Twelve institutions supplied data for the survey. The psychiatric departments range in size from 60 to 518 beds, with an average of 153 beds, and are associated with hospitals which have an average bed capacity of 1,495. The capital investment per bed of the psychiatric departments ranges from \$2,000 in an Eastern city hospital to \$22,754 in the very complete pavilion of a large nongovernmental hospital with extensive research laboratories, a large outpatient department and the most modern construction throughout.

The survey also presents data regarding the staff, patients and physical plants of these hospitals. Preceding the survey, Doctor Munger and Beatrice M. Bamber have presented two check lists, the first on planning and the second on equipping the psychiatric department.

New Jersey Gives Emergency Aid to Hospitals and Poor

By J. D. COLMAN

State of New Jersey Emergency Relief Administration,
Newark, N. J.

REQUESTS for assistance from several private charitable hospitals which were faced with the need of receiving increased support or curtailing their increasingly demanded free services were first received by the New Jersey Emergency Relief Administration late in 1932. The propriety of granting this necessary assistance was discussed and a rapid survey of the situation instituted.

The problem resolved itself into three questions: (1) Is there need of financial assistance to private charitable hospitals, and, if so, what is the extent of this need? (2) If there is such a need, should aid be extended by this temporary relief agency? (3) If this agency should extend aid, by what method should this aid be extended?

Need of financial assistance was interpreted to mean the inability to meet the direct operating costs of necessary hospital service to patients who could not pay the cost of their care. The extent of need was interpreted to mean, for the purposes of this survey, the net deficit of the hospital, with amortization and depreciation not being considered as expense, and any loss sustained in the operation of private and semiprivate facilities being excluded from consideration.

Expansion Beyond Community Needs

The survey showed that many hospitals had expanded their plants beyond the immediate service demands of the community (which in proportion to capacity have been steadily decreasing since 1930) and beyond the existing ability or inclination of the community to support this expansion. In the four-year period between 1929 and 1933, in nineteen New Jersey hospitals, income from patients had fallen 18 per cent and income from voluntary contributions decreased 38 per cent. Along with these alarming decreases of income came a falling off in the number of patients using the private and semiprivate services, the only services operated at a profit to the hospital, and a marked increase in the demand for ward care.

Inability of municipalities and counties in New Jersey to maintain their usual appropriations to private charitable hospitals and to support the indigent in the state brought about the development of the emergency program which is described here

At the time this survey was conducted, there were at least ten hospitals in the state seriously considering the curtailment of all free service which they could not finance from current income. This curtailment would have meant that the service areas of these hospitals would have been totally unable to meet the health needs of their indigent.

Need of Financial Aid Imperative

The possibilities of added support to the hospitals from sources other than the administration were carefully considered. The record of tax collections was so universally poor at the time that additional support from local tax funds was, with few exceptions, impossible. The hospitals had for the most part completely tapped whatever sources of current revenue were available from private philanthropy and it seemed that there was no other source of income open to them. These factors all pointed toward the fact that the hospitals were really in need of additional support if their services were to be continued.

This need must be differentiated from the need usually spoken of by hospitals. It was not a question of buying equipment for a new operating room or expanding the children's ward or anything of that sort. It was an absolute, indicated need of further financial support if the most limited services were to be maintained. The survey was not able to express quantitatively the extent of this need, but it was estimated that during the first year of operation the cost of the program which it proposed would be about \$600,000. During the first year the amount actually expended was approximately \$570,000.

Since the first question was answered affirmatively, even if the definite extent of the need was not quantitatively determined, the next question to be answered referred to the legal right of a temporary relief agency to extend this aid.

In the enabling legislation of the New Jersey Emergency Relief Administration, the purpose of the administration was expressed as being to supplement local resources for fulfilling the requirements of the permanent poor laws of the state when such local resources had proved inadequate. Under the provisions of Chapter 132, Public Laws of the State of New Jersey, 1924, the municipal overseer of the poor is responsible for meeting the cost of medical care to indigent persons.

Therefore it seemed that the administration was perfectly within its legally constituted authority in extending such aid to hospitals. Even though this provision has been in effect since 1924, there were practically no communities in the state that had ever met the provisions of this law by properly supporting private charitable hospitals for the cost of the care of the indigent. However, this did not interfere with the legal right of the administration to make such payments.

Inaugurate Present Financial Program

Having determined the need for financial support and the propriety of rendering such support, there still remained the problem of deciding how this support should be given. Two concepts guided the formation of an answer to this question: first, that the real purpose of the administration was to supplement inadequate local resources; second, that after all sources of revenue had been properly allocated according to their source, most New Jersey hospitals would be adequately supported for free services to residents of the municipalities in which the hospitals were located, and that the operating deficits of most hospitals, as defined in the answer to question one, were comparable to the cost of free service rendered to residents of municipalities within the hospitals' service areas which did not adequately support the hospital for this free service. The joint consideration of these two concepts and the fact that all payments from relief funds are required by law to be made on behalf of a specific person, led the administration to inaugurate its present program.

When a request for financial assistance is received by the administration from the board of governors of a private charitable hospital, the financial status of the hospital is carefully analyzed by a qualified member of the administration's headquarters staff. On the basis of need, as defined in the answer to question one, the net deficit of the hospital during a recent period of operation is

determined. This deficit is allocated among the various communities whose residents the hospital serves on the basis of their support and use of the hospital's facilities.

An estimate is then made of the number of days' care which the hospital will render the emergency relief clients in these municipalities, and by division a per diem rate is obtained which, if received by the hospital for each day's care rendered to relief clients, should enable the hospital to operate without incurring any additional indebtedness.

\$3 Is Maximum Per Diem Payment

The data so analyzed are then presented to a group of advisers appointed by the New Jersey Hospital Association, and after discussion and approval the rate schedule is made effective. It is evident that there is a different rate schedule for each hospital and for each community which uses the hospital. These rate schedules are reviewed at the request of a hospital or at the discretion of the administration. Because of some very unusual cases, it was necessary to fix the maximum per diem payment which the administration would make at three dollars.

The mechanics of the program consist of the hospitals' obtaining an authorization to render service to an emergency relief client from the district office of the administration and using this authorization to support a bill to the administration at the flat per diem rate established as outlined above.

In May, 1934, the program had been in effect for one year and some \$570,000 had been paid to fifty-four private charitable hospitals in New Jersey. At the present rate at which payments are being made to hospitals it would appear that during the year ending May, 1935, these fifty-four hospitals would receive about \$850,000.

State and Municipal Funds Are Used

It must be remembered that this program of financial aid to hospitals was inaugurated before the inception of the FERA and that the present program is being financed entirely from state and municipal funds, and that financial support given to the New Jersey Emergency Relief Administration from the FERA cannot be used to finance this program. The greater part of relief funds made available by the state government have come from the sale of bonds. It is from these state funds that the larger part of these payments to hospitals have been made.

The question of the responsibility for the cost of the indigent sick has been actively discussed by legislators, municipal governing bodies and hospital administrators in this state. Under present leg-

isolation the municipal overseer of the poor is directly responsible for this cost. However, in most cases the funds available to these overseers are limited and they have been unable to meet any appreciable part of this cost with the exception of Newark, Jersey City and Irvington, in which municipally controlled hospitals are maintained.

County boards of freeholders are also permitted to make appropriation to general hospitals for the care of indigent persons. In some cases these are almost adequate, in others they are pitifully inadequate. Under the program instituted by the New Jersey Emergency Relief Administration, combined state and municipal funds are also meeting a small share of this responsibility.

Since many persons interested in the broad phases of the problem of financing the hospital care of indigent persons feel that this can be most satisfactorily handled by the local governmental units, it has been the earnest desire of the administration to view this program of monetary aid to general hospitals in the light of a purely emergency measure. It has been designed with the hope that the relationships between hospitals and municipalities will be strengthened rather than weakened, and that should the emergency relief administra-

tion cease to function, the position of the hospitals in obtaining proper support for the care of the indigent sick would be fortified. It was anticipated that the operation of this program would crystallize the responsibility of local governmental units to support an agency which serves their community, even though not located therein.

The basis on which cases are accepted as being the responsibility of the emergency relief administration is necessarily a rigid one. It would be most helpful if the attention of physicians and administrators were focused thereby on the importance of thorough credit determination practices in hospital admission procedure. If these two things are accomplished it would seem that the program had contributed to the development of sound hospital practice in this state.

When this program was first contemplated, the New Jersey Hospital Association was asked to appoint a committee of advisers to the administration and for the last twenty months the original committee has done yeoman service for both the hospitals and the administration. It was largely through the foresightedness of this group of experienced hospital administrators that the worst pitfalls of such a program have been avoided.

Good Will and Account Collection

By JOHN C. DINSMORE
Superintendent, University of Chicago Clinics

THE proper way to handle collections and credits is to have all payments in advance. I recognize the difficulties of carrying out this program completely but I also recognize that when we have the money in our hands before the service is rendered we not only avoid piling up considerable expense in collecting accounts but we also build up good will for the institution.

It is an old adage in industry that the person who pays his bills promptly, all things else being equal, tends to continue to buy from the firm who requires such payments and that the person who pays his bills slowly and has to be continually pressed for payment tends to give his more profitable business to other companies. Obviously it is foolish to go to great lengths to build up good will for your institution on the one hand while on the other hand you must continually destroy good will through the necessary pressure brought to bear upon delinquent accounts.

We cannot get all the money in advance but the next best thing is to get as much in advance as we can and endeavor as nearly as possible to keep that account constantly paid up. When the patient is admitted a complete plan should be made which calls for the maximum advance payment so that when the patient is discharged there will be a credit balance instead of a debit balance. In this way the hospital experience is ended as soon as the patient leaves the institution.

If he leaves with a debit balance collection may be dragged

out over many weeks or months with the net result that any good will which might have existed when the patient left the hospital has been destroyed and in its place is the active ill will of the patient, his friends and relatives. Moreover, as we continue to press the patient for payment he becomes increasingly critical of the quality of medical care he received while in the institution.

I know of no institution, however, that has been able completely to solve this problem. Since this solution is not possible the next step is meticulously to follow the account as soon as it has been opened and to see that the process of collecting the bill is carried out as expeditiously and as nearly perfectly as possible.

I have found the use of form letters entirely unsatisfactory. I have also found that it is necessary to turn over every account every ten days in order to make sure that the accounts are kept in reasonably good condition. As these accounts are turned over and inspected, personal letters are written continuously reminding each debtor of each promise which he has made to pay and acknowledging the payments that have been made. I recognize that this adds a considerable burden to the clerical work in the credit office but I sincerely believe that when accounts are handled in this manner we lose less good will and we get a maximum return on the accounts receivable.¹

¹Read at the Institute for Hospital Administrators, September, 1934.

What Others Are Doing

Protecting Patients' Histories in the Wards

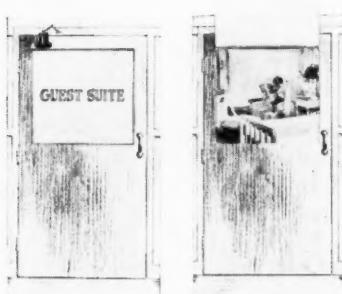
The old problem of how to keep patients' histories protected while they are being used in the wards has been neatly and inexpensively solved by the University Hospital, Ann Arbor, Mich., of which Dr. Harley A. Haynes is director.

The history itself is backed by a heavy sheet of brown paper, made up with a clip at the top by means of which the pages are fastened together. This is covered by a sheet of safety film, 9 inches by 12 inches, and the whole thing is mounted on an aluminum chart back, and held in place by the clip.

When this system was first installed the hospital used its own discarded x-ray films, cleaning them. Now they buy used 9 by 12-inch safety films, cleaned and ready for use for about \$18 a thousand. These are used for about two months before they have to be discarded, and the cost of protecting the histories amounts to about one cent a month apiece.

Bookmark Tells Guest Suite Story

A factor which has contributed greatly to the success of the "Guest Suite" at Orange Memorial Hospital, Orange, N. J., is the effective publicity which F. Stanley Howe, director, has employed to popularize this interesting feature of the institution. For those who may have missed the ar-



ticles on the guest suite that have appeared in The MODERN HOSPITAL, it may be said briefly that it comprises a group of ten rooms with private solarium wholly devoid of hospital at-

mosphere and available to those who seek rest and relaxation.

To carry the thought into the community, Mr. Howe has devised a clever little bookmark, an exact facsimile of the closed door with the window marked "Guest Suite," which leads into that particular section of the hospital. This door, incidentally, has been featured in all publicity pertaining to the guest accommodations to the point of becoming almost a trademark. The window on the card raises up forming a flap which can be slipped over the top of the book page, disclosing a view of one of the exceedingly attractive bedrooms with a guest reclining on a chaise longue engrossed in a magazine.

The back of the card bears the following legend: "The place to enjoy a good book is in the guest suite where 'silence like a poultice comes to heal the blows of sound.'" It goes on to present an alluring picture of such luxuries as meals in bed and every service catering to personal comfort. Rates depending on choice of room and length of stay, it is explained, will be furnished on request.

The card is but 3 1/4 inches long and 2 inches wide, yet it tells the whole story effectively. Another asset is that it performs a useful function.

Maintenance Fund Ensured Without Money Drives

Mount Vernon Hospital, Mount Vernon, N. Y., is a voluntary hospital in the fortunate position of never having to campaign for maintenance funds. Five years ago, when voluntary contributions became scarce and the community chest fund was inadequate to support the fifteen charities dependent upon it, the hospital and the city officials worked out a plan that ensured the hospital maintenance without contributions.

The city agreed to pay the hospital almost the full estimated per capita cost for the care of the indigent sick instead of the low rates usually paid by municipalities for such cases. It also agreed to pay the difference between the ward rate, charged those who are able to pay something for their care, and the approximated cost.

One dollar, which has since been

reduced to seventy-five cents, was paid to the hospital for all dispensary and first aid treatment of indigents, and when partial payment by the patient is possible, the city pays the difference.

The plan has been satisfactory to both the city and the hospital, for it means that each taxpayer who has the privileges of the hospital pays his pro-rata share of the maintenance. The actual increase in the tax rate is small, while the hospital itself enjoys a financial freedom it lacked before the plan was put in operation. Mount Vernon Hospital has 185 beds and serves a community of about 75,000 people. Prior to 1925 it was entirely dependent upon annual contributions to cover its deficit. Mary A. Land is the superintendent of the hospital.

Bequest Forms Included in Annual Reports

Inspection of annual reports received in the office of The MODERN HOSPITAL indicates that a considerable group of hospitals are including forms for bequests in the reports. Provident Hospital, Chicago, has gone somewhat further and has put its forms on a perforated sheet which is easily detachable. The forms used by this hospital are as follows:

ANY PERSON DESIRING TO BEQUEATH A LEGACY TO THIS CHARITY IS REQUESTED TO DO IT IN THE FOLLOWING MANNER, VIZ.:

FORM OF DEVISE OF REAL ESTATE

I give and devise to Provident Hospital and Training School Association, of Chicago, a corporation existing under the laws of the State of Illinois, for its corporate purposes, all that, etc.

(Here describe property)

.....
.....
.....
.....
.....

ANY PERSON DESIRING TO BEQUEATH A LEGACY TO THIS CHARITY IS REQUESTED TO DO IT IN THE FOLLOWING MANNER, VIZ.:

FORM OF BEQUEST

I give and bequeath to Provident Hospital and Training School Association of Chicago, a corporation existing under the laws of the State of Illinois or to the Treasurer thereof for the time being for its corporate purposes, the sum of

..... Dollars.

Following the Care of the Baby From Hospital to Home

Many a mother has gone home from the hospital fairly confident that she knew how to care for her baby, only to discover that her limited facilities made difficult even the simplest things taught her during her stay.

Sutter Hospital, Sacramento, Calif., eliminates much of this difficulty by sending a maternity nurse to call on each discharged guest the second or third day following her return home. The nurse coordinates the instructions received at the hospital with the apparatus available for the patient's use, and consequently eliminates many knotty problems that would otherwise trouble the young mother.

The hospital, of which R. D. Brisbane is superintendent, makes no charge for this service.

St. Louis Hospital Conducts Administration Course

The Jewish Hospital, St. Louis, of which E. Muriel Anscombe is superintendent, has affiliated with Antioch College, Yellow Springs, Ohio, and with Washington University in St. Louis, to offer a course in hospital administration.

Under the present plan, the Antioch students spent ten weeks at the hospital and ten weeks at the college, alternating academic work with the practical application of theory and continuing these ten-weekly alternations during the college course.

At the hospital the student is given training in every department and his work is constantly supervised by the heads of the different departments who have outlines of the work the student is expected to cover. The superintendent holds weekly conferences with the student, reviewing his work and assigning correlative reading material which is taken from hospital magazines, textbooks and other sources.

When a student enters the course he is first assigned to the medical wards, and his reading is concerned with medical supervision of wards, departmental organization, planning and equipping wards, types of material used in the construction of the building, importance of proper food service to patients, and the necessity of prompt execution of orders.

At the end of his service in this division, he is given a review on his work and his reading by Miss Anscombe, who receives a report from the

department head on the student's efficiency and attitude toward the work. This is carried on in each department of the hospital. Training in the administrative department is the last received.

One lecture a week, two hours long, is given by Miss Anscombe at Washington University, in a thirty-week course covering hospital administration. The first semester's work includes the importance of a survey previous to a building program in communities with hospitals and in communities without hospitals, general

Murals Aid Imagination of Children

The children at the Grady Hospital, Atlanta, Ga., are making up stories about geese and enchanted princesses, and a little boy who lives in a cabin half hidden behind a hill. J. B. Franklin, superintendent of the hospital, and Mrs. A. Farnsworth Drew, the artist who painted the hospital's new murals decided before work started that rather than have the paintings tell stories in a complete form they wanted something that could capture the imagina-



plans and layouts of hospitals, and equipment. The second semester deals with the administration of the hospital, that is, the hospital's community relations, relation to agencies, public health, the organization of each department in the hospital, the sum total of all departments, and what a superintendent should know pertaining to each of the many departments she will be called upon to supervise.

This course was given last year at the university, also, and one of the students has enrolled at the hospital for six months to correlate the subject material given in the lectures with actual hospital practice. The work this student is doing under Miss Anscombe's direction is quite different from that done by the Antioch students, as the student has both her R.N. and B.S. and had much experience in hospitals before she entered the class devoted to administration.

tion of the children and become a personal part of them.

The painting is divided into three panels, with a background of an idealized Georgia landscape in all of them. The hill which half hides the cabin in one panel is green, but the bank on which the child stands is the red clay of Georgia, and the peach tree in bloom beside him is familiar to all Georgia children. This combination of familiar objects, moving animals and uncompleted incidents quickens the interest of young patients.

The physical plant of the hospital has been extensively improved during the past year and a half through PWA and FERA funds. The unit of the pediatric department for white patients has been completely rebuilt, and each ward is now divided into cubicles which simplifies the prevention of cross infection. A formula diet kitchen was built and is supervised by a dietitian.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Good Administrators and Small Hospitals

By EDWIN R. EMBREE
President, Julius Rosenwald Fund, Chicago

THOSE of us concerned with hospitalization outside large metropolitan areas are apprehensive because of the continual loss of competent personnel by town and rural hospitals. Sooner or later as the administrator of the small hospital demonstrates exceptional ability he is sought by the larger hospitals, and if he shows any natural desire for advancement he is eventually impelled to accept the position that pays more or provides greater recognition or both.

This is a natural trend in all fields of activity. It is especially noticeable in commerce and industry. Even in such social institutions as schools and colleges the trend of ability is from the small community to the larger. Traditionally, social opinion frowns upon this trend and considers it a weak yielding to the course of least resistance. Nevertheless it is certainly natural and in many of its expressions it need not be viewed with alarm.

What Is Happening in Industry

In commerce and industry the trek first to the town and then to the large city is inevitable as long as commercial and industrial activities are being so overwhelmingly concentrated. This draft does not, however, rob the rural community of the services and products of commerce and industry. Good transportation will deliver a radio to a farmer 200 miles out of Chicago almost as fast as one can be delivered to the urban resident. Even the concentration of certain social services in the larger centers does not leave the rural community at any great disadvantage. With modern means of transportation and communication, the grown student from the small town may attend a large urban university as conveniently as he can go to a small college in the next county.

But there is an essential difference between the hospital and other social institutions or commercial and industrial activities. The service area of a hospital is of necessity its immediately surrounding geographic area. Most persons requiring hospital and medical care need to be in close touch with the family home and the family doctor for many reasons, both psychologic and economic. Furthermore the out-patient clinic and the other health services of the hospital must of necessity

concentrate on the immediate locality.

Taken in large view, it is just as necessary for the town or rural community to have distinguished hospital service, although rendered on a smaller scale, as it is for the large metropolitan area to have it rendered on a large scale.

In the long run this situation can obtain only if hospital administrators of exceptional ability are retained in the town or rural communities in the same proportion as they exist in the larger hospitals in urban centers.

Happily there is now a general trend in American life away from the great urban agglomerations and back to a regard for fine living in towns and villages. Community hospitals may aid this movement by offering increasingly excellent services in the smaller centers; they may benefit by the trend through finding it possible to retain their finest personnel.

To hold able administrative personnel in the smaller hospitals, however, their salaries must be increased and every effort made to give prestige to high service rather than to connection with large institutions. Those responsible for the smaller hospitals must be brought to realize that frequently it is more important and in the long run more economical to raise an able superintendent's salary than to be continually paying for the education through "trial and error" of an inexperienced executive.

Incidentally, better rural hospitals will attract better physicians to rural communities.

Men and Materials

This same problem comes back to us in many ways in all rural activities calling for professional or highly trained personnel. And it is not only in rural communities that this problem arises.

Before we can make the progress which is possible in almost any field of social action we must see more clearly the difference between the usefulness of highly able men and the uses of materials, machines and techniques which these men may employ. We cannot substitute materials for men.

The best machines made and the most effective techniques evolved for any purpose are highly specialized and in most instances their uses are narrow. The one lesson we are fast learning is that the most effective machines and techniques are not widely adaptable to a great variety of work and often lie idle in unusual or fast changing conditions. In contrast, the highly able man shows his usefulness in every situation he meets.

An Abuse Is Uncovered

By REBEKAH F. DUNNING

Supervisor, Out-Patient Department, Hospital for Joint Diseases, New York City

PRESENT methods in the manufacture and sale of corrective appliances constitute one of the most serious problems still to be solved by the medical profession and allied groups. The evil lies in the fact that an unlicensed group of mechanics or retail merchants has assumed the privilege of designing and applying apparatus intended for the alleviation or cure of physical ailments without medical supervision. That many of these workmen are proficient does not alter the situation since the untrained man cannot be discovered or eliminated under existing conditions.

The making and fitting of an orthopedic brace, a truss or a corset is a matter that requires medical knowledge and special training as well as mechanical skill. An ill-fitting support is anything but corrective and may be definitely injurious. Although these facts are known and recognized by the medical profession and by many of the appliance manufacturers themselves there has been an amazing apathy in the approach to the situation.

There are two sources of supply for corrective appliances and shoes. One is the small shop which supplies handmade products to the consumer and the other is the factory, producing machinemade products for wide distribution through the retailer. The appalling abuse lies in the fact that any person may go into this relatively lucrative business of making and selling appliances and shoes without accounting to anyone for his qualifications. There is no civil or medical supervision and no special training is demanded. A person may buy any appliance which he feels he needs or which has been suggested to him by an advertising billboard without a physician's order and the dealer uses his own discretion in fitting the product. The factorymade appliances are distributed through drug, department and specialty stores where they are sold to the customer by clerks who know even less about fitting them than the manufacturer. The public can and does buy these appliances in the same fashion as it buys clothing. While everyone understands the needs and uses of clothes, few can be expected to understand the anatomic and

physiologic factors involved in the application of a brace, a corset or a corrective shoe.

Frequently patients come to the out-patient department of this hospital wearing ill-fitting braces, trusses, abdominal belts or shoes which have been purchased at retail stores or specialty shops. Often medical examination discloses the fact that they are wearing supports that are not needed or that are in some instances actually harmful to them. An example from our own clinic is the following case. A boy of fourteen suffering from paralysis of both legs following poliomyelitis came to us wearing double leg braces purchased from a retail appliance dealer. No physician had prescribed them. These braces were so constructed and applied that our orthopedic staff declared them to be increasing the deformities and contractions already present in the patient. This, I may add, is not an infrequent occurrence in our experience.

There are some surgical appliance makers and

Ways to Control the Evil

1. All manufacturers and dealers in corrective or supportive appliances should be required to meet definite minimum standards set up by a committee controlled by the state.
2. Only those able to meet these standards should be licensed.
3. No person should be allowed to sell such articles without a physician's prescription and the physician should supervise the fitting of the appliance.
4. Medical schools and hospitals should educate their students and staff physicians in the use and application of surgical appliances.
5. There should be some effort on the part of the medical profession and manufacturers to prevent the practice of fee splitting.
6. Trade schools should offer courses in the production and applying of surgical supplies and the licensed factories or hospital brace shops of the country should work out a system of apprenticeship to train those interested.

corrective shoe dealers who do require a physician's prescription before they will make or sell any therapeutic support for a patient. Many times physicians, due to lack of interest or proper training, authorize the appliance maker or shoe dealer to prescribe and apply such apparatus.

A particularly difficult problem in the present situation is the method used by both the manufacturers and the physicians in advertising and selling their products. Surgical appliance makers and shoe dealers solicit business from the medical profession and from hospitals by offering attractive commissions and rebates. The following quotation from a letter received by this hospital from an orthopedic shoe dealer is an example: "Many hospitals are getting a remuneration on all surgical and orthopedic appliances recommended by their staff physicians and thereby helping to lessen their operating expenses. We have a very liberal plan that will enable us to cooperate with you." This type of solicitation appeals to many persons and unfortunately patients are often sent to the surgical supply store which has offered the highest commission, rather than to a store that can give them the best appliance for their needs. The recognized evils of fee splitting arise as readily between appliance maker or shoe dealer and physician as between physicians themselves.

Good Bracemakers Are Scarce

There is a scarcity of well trained appliance makers in America. In our hospital brace department which is staffed by eight full-time bracemakers, we have found it difficult to obtain good bracemakers when we need them. It is a highly specialized field and those who have been properly trained have usually served a three to five-year apprenticeship in Europe. There are no established schools or apprenticeships in this country to train men in this type of work, and until such a training method is developed no satisfactory system can be worked out.

We have recently established in our hospital three apprenticeships in our brace department in order to develop a trained personnel for our future needs. If brace departments in all orthopedic hospitals in the country would do the same, we could in about ten years turn out an adequate number of well trained workmen to fill the needs of this industry.

Abuses inherent in this problem are as follows:

1. Any person may conduct a business of manufacturing, applying or distributing corrective appliances and the so-called orthopedic shoes regardless of his training or ability.
2. Any person may purchase a brace or other corrective appliance without medical supervision.

3. Physicians are not properly trained in the need for or in the application of surgical appliances and corrective shoes.

4. The practice of giving commissions to physicians and hospitals is prevalent and unethical.

5. There are no adequate training facilities in America for manufacturers or dealers of surgical appliances and corrective shoes.

Certainly these conditions constitute an evil comparable at least to that of the old uncontrolled patent medicine industry. New York State has by legislation set up various laws to protect the public. Opticians, physical therapists, druggists, architects and similar occupational groups are licensed by the state. To receive a license the individual must be able to meet established standards of training and ability.

All manufacturers and dealers in corrective or supportive appliances should be required to meet definite minimum standards set up by a committee controlled by the state. Only those able to meet these standards should be licensed. No person should be able to sell such articles without a physician's prescription and the physician should supervise the fitting of the appliance. Medical schools and hospitals should educate their students and staff physicians in the use and application of surgical appliances. There should be some effort on the part of the medical profession and manufacturers to prevent the practice of fee splitting. Trade schools should offer courses in the production and applying of surgical supplies and the licensed factories or hospital brace shops of the country should work out a system of apprenticeship to train those interested.

I believe that these suggestions are feasible and should be developed in the near future in order that the present abuses of an industry related to the public health may be brought under proper control and supervision.

Controlling Noise

Much has been said and done about maintaining quiet in hospitals. There are certain sounds, however, which cannot be eliminated and psychologically noise engenders noise.

In recent years, particularly, great progress has been made in the application of sound absorbing material, according to W. Mezger, superintendent, Knickerbocker Hospital, New York City. The market now offers materials which are entirely practical from the standpoint of initial cost, maintenance, and effectiveness, he declares. A correctly engineered installation will eliminate noises far below the annoyance level and in many instances produce unbelievable results.

Such obviously noisy places as duty and utility rooms, nurseries, dining rooms, waiting rooms, are as important, he says, as corridors.

Distinguished Service— Its Stimulus to Progress

OVIOUSLY, the average hospital must devote most of its effort to absolutely routine services. But it is the extra-routine or marginal activities that make for distinction.

Hospital standardization is fostered to promote a high quality of service over the widest possible area for the benefit of society as a whole. And in this sense high standard routine is essential to group progress.

In a more general sense, however, we realize that progress comes through the fact that individual hospitals render a service of extraordinary quality or fullness in some specific direction; that if the extraordinary service is found practical in specific situations it may be accepted generally. Thus group progress comes through the experimentation of the specific hospitals.

As a counterbalance to standardization, then, we should always encourage experimentation in nonroutine services. We must go even further. We must forever question our standard practices.

To give voice to this thought, "Distinguished Service in the Hospital — A Stimulus to Progress" appeared in the September issue. It was also thought that The MODERN HOSPITAL might provide a medium through which ideas and suggestions for distinguished service could be assembled, properly credentialed, organized and laid out in relation to each other and to the scope of hospital operation.

250 Opinions Summarized

A file of correspondence has grown up with over 250 representative men and women in the field of medicine, hospitalization and public health. Several hundred pertinent and thoughtful suggestions have been made. Many of them have been reiterated a score of times or more. And while most of them are not advanced as new or original ideas, many new side lights have developed on ideas to which the hospital field is giving widespread attention just now. Practically no ideas have been advanced unless they have had a practical trial.

So far, most ideas and suggestions offered relate to about forty separate and distinct aspects of the hospital's existence, and these in turn may be summarized as they pertain to (1) problems of organization, personnel and policy; (2) problems of current operation and service; (3) the relations of the

Over 250 persons sent in comments on the article on distinguished service which appeared in the September issue of The Modern Hospital. These statements have been carefully studied and correlated. The accompanying article is the first of a series of four summarizing this material

hospital to the public generally. This article will deal with the first group of problems.

To begin with it should not be assumed that this method of assembling a compendium of extraordinary services which might stimulate widespread progress is unquestioned, or even that all hospital men and women think extraordinary service (service above or beyond standard) very important.

Articles which attempt to bring together many suggestions from scattered sources may raise false hopes in that some ideas which seem generally good in one situation may not be good in another. Care must be exercised to see that only ideas which have somewhat general application are admitted.¹

Those who urge services above and beyond standard imply as a general proposition that hospital service should be broadened; that hospitals should cooperate much more extensively among themselves and with other health agencies, and that hospitals should in every case attempt to adjust themselves fully to community needs. This idea is not unanimous. Some hospitals undoubtedly prefer their present status to one which they might occupy if they cooperated with other hospitals and agencies to any greater extent than they do, or if they undertook any wider responsibilities to the community generally. For instance, some believe that to undertake the solution of public health problems is not and should never be the function of the hospital except insofar as proper and sufficient hospitalization is concerned.²

However, the preponderance of opinion was that hospitals today are dealing with a new situation³ and therefore we must re-make many of our ideas. In this situation it is generally agreed that the explorer of ideas is vitally necessary. The correspondents generally suggest that when the various possibilities for the amplification of hospital service are summarized they might be used as a basis upon which future service programs could be built.⁴ It is repeatedly observed that no better time could be chosen to launch new ideas for the improved care of the sick,⁵ and that hospital administrators everywhere need such ideas, want them and are more than ever searching for them.⁶

If Uniformity Is Pushed Too Far—

What about standardization itself? It is a well recognized fact that, like individuals, some hospitals find in standardization an idea which is too attractive. They are apt to believe that pushed to the extreme it is an answer to all problems of service and a good substitute for individuality and initiative. They may even see standardization as something which makes these other things unnecessary. Thus while the effect of standardization programs has been advantageous, it has at the same time been destructive of individuality, personality, and character in some hospitals.⁷ This comes about also because the objects of standardization campaigns are not always completely grasped. If they were all would understand that quality of service and a better knowledge of the work done are of far more importance than quantity of mechanization⁸ or extensiveness of standard practices.

Certain it is that during the last two decades hospitals have given more attention to physical facilities, quantitative service and technicalities than they have to the fundamentals of human relations and qualitative service.⁹

Those who best comprehend the purposes of standardization, most deplore making it an end in itself. To them a high standard of service is basic but no more than basic. All hospitals which possibly can should render service above any standardized program, but they cannot do that until they do the basic things.

One letter quotes a great philosopher as classifying hospitals into six groups: (1) commercial, (2) stagnant, (3) minimal, (4) mediocre, (5) progressive, and (6) eminent. The same letter ends with the admonition that no hospital should be content until it has, in its place, attained eminence.¹⁰ The consensus is that we should never be satisfied with standard service.¹¹

Therefore these articles are, no doubt, quite representative of what men and women in the hospital

field are thinking and doing, and of the spirit of open-minded exploration which now characterizes the field. And there is a substantial request that they be published.

Chronologically, the organization of a hospital board comes first. After that a charter must be obtained. From time to time it has been brought out that charters granted under old state constitutions often hinder a hospital's attempt to meet new social, economic, educational and sometimes public health requirements.

Repeated observations are made in this recent correspondence with regard to such difficulties and apparently they exist in more hospitals than would be imagined. Time and again it is brought out that hospitals which might otherwise cooperate more closely in general functions are restrained by arbitrary provisions in their charters. Other hospitals, particularly in large cities, desire to cooperate on operative and even administrative levels, but find it almost impossible within charter provisions. Many hospitals are distinctly handicapped by limitations placed before them at time of organization which might now be removed.¹²

Furthermore, trustees should review circumstances under which their hospitals came into being and have been maintained. Adjustments should be made to provide a better balance in activities, many of which may still be needed in the original or extended form, while others no longer serve the purpose for which they were created.¹³

Suggestions for proper methods of selecting hospital trustees were numerous, and the vein in which the suggestions were made indicates the seriousness with which this problem is viewed.

Measuring a Hospital's Success

The success and progressiveness of a hospital may be measured by the administration's success in its attempts to provide for needs of the community. And management must conscientiously follow the fundamental rules which regulate the distribution of administrative responsibility if any headway is to be made in this task. In the long view, a hospital cannot be sounder than its governing board. Yet, all too often, members of the board are chosen without thought of their ability to guide the policy and future of the hospital.^{14, 15, 16}

In many instances, selected board members serve for personal aggrandizement rather than because of their desire or ability to assist in the maintenance or improvement of hospital service. Often, because of friendship or kinship, board members come under the complete control of a few staff members.¹⁷ Frequently, administrators play board members off against staff members, and the reverse, to their own satisfaction. Board members

often meddle in affairs not their responsibility and neglect responsibilities plainly theirs.

Board membership should comprise those capable of interpreting the present and future requirements of the community, and also capable of determining progressive and prudent policies after drawing fully on the expert knowledge and experience of executives in their organization. Policies are the responsibility of the board. The provision of expert knowledge and management are the responsibility of the administrator and his assistants. The hospital falls short to the extent to which this division of responsibility is not recognized.¹⁴ The board should be small enough to present a united front in decisive action and large enough and active enough to obtain the necessary group opinion or consensus. Experience seems to indicate that standing committees to determine policy are not desirable.¹⁴

A Poor Board and a Poor Superintendent

Also there is a growing recognition that poorly qualified boards are almost entirely responsible for the unfitted and incompetent administrators who are scattered throughout the hospital field. One of the biggest responsibilities of the board is to select a fully qualified administrator. Yet boards do not even know where to look for trained executives. Frequently, they would not know one if they saw him, and if they happened to employ one by accident, they would not know what to do with him. They would probably circumscribe him the way they would an untrained one.¹⁵

And right here we come to the commonest and most crucial problem in hospital progress or distinguished service. It is the qualification and capability of the hospital administrator. Executive fitness is the keynote to distinguished service.^{15, 17}

It is admitted that better education of trustees to their duties in this direction is the fundamental approach to this problem but that is a slow process at best. And many thoughtful persons in the hospital have about concluded that if a superintendent is to be fit and trained, if he is to have administrative, professional and organizing ability, and a personality large enough to attract and hold competent assistants and inspire enthusiasm — if he is to have all these things, he must be selected by some rigid qualification system laid down by a competent and representative organization which will set about to rid the field of its incompetents.

Many feel that the organization of the American College of Hospital Administrators shows that progress is being made toward the elimination of inexperience and incompetence in hospital administration.¹⁸ Others feel that the problem calls for utmost vigor and direct action.

Criticisms and suggestions regarding trustees and administrators were no more general and pointed than discussions and suggestions relating to nurses' training and the nursing situation.

The problem is most frequently stated as one of properly training nurses and at the same time giving the best nursing care to patients at a cost they can afford to pay. Some observers believe that graduate nurse service must be endowed and, it is pointed out, this endowment might have a strong public appeal.¹⁹

Others see as the crux of the problem the fact that the present system of nursing education is submerged in and by other aspects of hospital operation. It is sharply contended that nurses' training must be given a more independent status and placed on a sounder basis.^{20, 21} In the opinion of several, the report of the Committee on the Grading of Nursing Schools offers irresistible proof that the present system is basically unsound and that the remedy lies along two lines — the replacement to a considerable degree of student nurses by graduate nurses, and the placing of the training schools under an independent board of managers interested primarily in education. It seems to these critics that the present system is grossly unfair to the student nurses and that it is working real damage to the public as a whole.²¹

To summarize, it seems obvious that it will not be greatly improved until the training schools are more independently organized and so financed that the educational needs of schools need not be sacrificed to the financial needs of hospitals.²⁰

The next article will deal with problems of general policy in the hospital and specific services rendered by some hospitals beyond the usual.

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- ²George Crile, M.D., Cleveland.
- ³A. M. Calvin, superintendent, Midway and Mounds Park Hospitals, St. Paul, Minn.
- ⁴Richard B. Dillehunt, M.D., dean, medical school, University of Oregon, L. C. Fallis, M.B., superintendent, Victoria Hospital, London, Ont., J. B. Franklin, superintendent, Grady Hospital, Atlanta, Ga., J. Allen Jackson, M.D., superintendent, Danville State Hospital, Danville, Pa.
- ⁵Haven Emerson, M.D., College of Physicians and Surgeons, Columbia University.
- ⁶Walter E. List, M.D., superintendent, Jewish Hospital, Cincinnati.
- ⁷Ray Lyman Wilbur, M.D., president, Stanford University.
- ⁸M. H. Eichenlaub, superintendent, Western Pennsylvania Hospital, Pittsburgh.
- ⁹A. C. Bachmeyer, M.D., director, University Clinics, University of Chicago.
- ¹⁰Malcolm T. MacEachern, M.D., director of hospital activities, American College of Surgeons, Chicago.
- ¹¹Howard H. Johnson, M.D., superintendent, St. Luke's Hospital, San Francisco.
- ¹²Benjamin W. Black, M.D., medical director, Alameda County Institutions, Oakland, Calif.
- ¹³E. M. Bluestone, M.D., director, Montefiore Hospital, New York City.
- ¹⁴R. Fraser Armstrong, superintendent, Kingston General Hospital, Kingston, Ont.
- ¹⁵Charles A. Wordell, superintendent, St. Luke's Hospital, Chicago.
- ¹⁶Charles H. Young, M.D., director, Mountainside Hospital, Montclair, N. J.
- ¹⁷J. Dewey Lutes, director-general, American College of Hospital Administrators.
- ¹⁸John R. Howard, Jr., former superintendent, New York-Cornell Medical Center, New York City.
- ¹⁹Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.
- ²⁰Winford H. Smith, M.D., superintendent, Johns Hopkins Hospital, Baltimore.
- ²¹C.-E. A. Winslow, Dr. P.H., school of medicine, Yale University.



The Spirit of the Frontier Wins

By RAYMOND P. SLOAN
Associate Editor, *The MODERN HOSPITAL*

FIRST, let us set the scene. Fertile fields and meadows slope down to the shores of the Missouri River as it winds its way leisurely through the town of Chamberlain, S. D. Expansive wheat fields stretch as far as the eye can reach, forming vast oceans of grain rippling musically to the accompaniment of the soft wind and unfolding miraculously under the rays of the warm sun.

This was before the plague of grasshoppers brought destruction to South Dakota and in the days preceding the great drought. Bad times have since fallen upon the farm lands — strong stalks of growing wheat have been choked by the hardening scil, their graceful shoots withered under the relentless heat of a scorching sun. We are in the heart of an agricultural country which for three years has had no crops and three-eighths of whose people are on federal relief.

The dauntless spirit of the frontier still prevails, however. Even with conditions at their best, the finest wheat to be found anywhere sold for as little

An agricultural community for three years without crops and with three-eighths of its people on federal relief, yet boasting a hospital that is self-supporting! Chamberlain, South Dakota, is the goal of this month's Little Journey, which tells how a hospital meets its obligations with the dauntless spirit of the frontier

as ten cents a bushel, with other produce in proportion. Given a fair opportunity, the fields will again furnish their former quota of fine crops, which at reasonable prices will afford adequate living at least.

Twenty-nine years of hospital work on the frontier have revealed many important facts. Most significant is it that a hospital serving a community such as that described can be made practically self-supporting despite adverse conditions.

Before studying certain aspects of the Chamberlain Sanitarium and Hospital as it stands today amidst beautiful lawns with groves of elm, cedar and cottonwood bordering extensive farm lands, something should be known of its character and background. It is a general hospital, for example,

providing for the treatment of all diseases with the exception of tuberculosis and mental ills. Accommodations include 56 private rooms, 12 two-bed rooms, 1 four-bed ward and 6 bassinets. One hundred and twenty-five patients can be provided for, if necessary.

Now let us look back briefly twenty-nine years when the hospital was first organized. Dr. C. P. Farnsworth, superintendent, draws a vivid picture of those old times. "There were no hospital facilities west of Sioux City, Iowa, or Sioux Falls, S. D.," he explains. "St. Joseph's Hospital in Mitchell was in process of construction so there was a stretch of territory more than three hundred miles east and west and one hundred and fifty miles north and south with no hospital facilities. The country west of the Missouri River had just been opened for settlement and the Milwaukee Railroad was being brought west to Rapid City. Every quarter of good land, and every half section of land not so good had on it a settler who was proving up. For a number of years there had been excellent crops in all this part of South Dakota and people moved in rapidly from the East to settle on the fertile soil."

"When the hospital was first erected, it had room for about forty patients. Before it had been open six weeks, some sixty or seventy patients were crowded in. The work was along general hospital lines with a great many surgical cases and many treatments for blood poisoning."

"Since that time 80,000 patients have been treated. Last year alone the number of patients totaled 3,178. Never once has the hospital closed

its doors from the day they were first opened."

Today Chamberlain Hospital is an independent institution operated without profit. The only two concessions it receives are exemption from taxes and free water furnished by the city of Chamberlain. It is nonsectarian and is not controlled by either county, state or charitable associations. A board of seven governors is responsible for its operation. These directors are appointed to serve three years and are elected by the Chairman of Lodges, commissioners of Brule, Buffalo and Lyman Counties, pastors of churches and employees of the institution who have been in its service for more than a year. These individuals vote once each year for directors whose terms have expired.

Four resident doctors are in charge, including Doctor Farnsworth. A nurses' training school connected with the hospital offers a three-year course and meets all the requirements of the state and national nurses' association. It is affiliated with the University of Minnesota nurses' training school in Minneapolis. Girls in training number about twenty-four and nine graduates act as supervisors in the different departments. Approximately 140 nurses in all have been graduated and are today engaged in health service all over the world, from Russia to China, east and west, and from Canada to the Argentine, north and south.

The hospital offers a complete hydrotherapeutic department for men, also for women with a complete electrical department, all under the direct charge of specialists in these particular fields. The technical facilities include x-ray, blood, urine and



Here are the hospital's nurses and domestic help. Students taking the three-year training course number about twenty-four.

gastric laboratories and a pathologic department for the examination of tissues removed in surgical operations. These are all under the supervision of a competent doctor and three nurse assistants. A trained dietitian is in charge of all diets. The institution is in good repair and the equipment is equal to that of any in the northwest country.

Doctor Farnsworth confesses amusement at hearing about hospitals in other sections of the country receiving charity cases as low as \$4.50 a day. Rates at Chamberlain are \$1.50 a day which includes board, room and general nursing. Medicine and dressings are extra. There is a flat charity rate of \$47 for confinement and nine days' care for mother and child. At the present time considerable work is being done for the local counties, seven of them being tributary to the hospital. Major operations for the county are done for as low as \$25 with the charges for one week's care in the hospital \$30, including operating room expenses.

"We do not ask for credit," Doctor Farnsworth emphasizes. "We pay cash and take advantage of cash discounts. Even in these trying times, we have all our purchases sent C. O. D. so there is no possibility of getting into debt.

"Similarly, we will not take in people who cannot either present us with an authorization for their work by a county commissioner or make an advance payment for their care. By such action we can charge less to those individuals who are provident enough to save for an emergency. We do not make the provident pay for the careless and improvident by unjustly charging them with the 'no-goods' bills. Of course, emergency service, accidents and the like, must be taken care of at once but the people are being educated so that they expect to make some arrangement as soon as the sick one enters the institution."

Solvent, but Little More

To which he adds the following significant statement, "We owe no bills that are twenty days old but we have no great amount of ready cash."

There have been economic problems, many of them. For example, some twenty-four years ago an epidemic of typhoid fever broke out in the western country. Within a few days seventeen very sick patients were brought in for which the hospital must provide. They required extra nursing and special care which cost approximately \$6,000. No recompense was ever received for this service.

Some years ago sixty-six people advanced the hospital \$40,000 and took out notes payable in board, room and treatment. These have all been retired with the exception of about \$7,000. How has this been accomplished? How can a hospital of this type be made self-supporting? By checking

carefully all the financial arrangements before the patient enters the hospital for treatment. This has already been covered. Further, by developing various resources of the institution to the point where they become productive and enable it to be practically self-sustaining.

Hospital Runs a Commercial Laundry

The matter of laundry work was a problem for a time. Laundries charged exorbitant prices and on occasions it was even necessary to send the work to Albert Lea, Minn., a distance of some five hundred miles. The only solution was for the hospital to install its own laundry. Power washers were set up, a mangle installed with two large extractors, a drying room, a tumbler, steam presses and electric irons.

With what result? Today in addition to doing its own work, the hospital conducts a commercial laundry service for the city and surrounding country. The earnings not only pay for the laundry work of the hospital but add to the gross earnings and help defray expenses. During the summer, five skilled workers are employed, and the average amount of money received for laundry from outside is about \$400 a month.

Likewise, when the hospital was first established, milk was bought from a local dairy, other foods as well. The result was that when a convention happened to be taking place in the city, the dairy man would not deliver milk to the hospital but would haul it into town where he was assured a better price. Sometimes 37,000 people would be present on such occasions for land drawings, the town having at the time approximately 1,500 inhabitants. In consequence, there was no way of supplying the needs of the sick other than a trip over bad roads to Mitchell, the only place of any size for supplies.

There was only one answer to the problem — to establish a dairy for the hospital's exclusive use. Today a heard of thirty-nine cows and ten heifers graze in a pasture comprising 800 acres. The hospital also has a farm of tillable land covering 500 acres which furnishes the feed for the livestock. A model barn has been erected which will accommodate sixteen cows in stanchion. Individual drinking fountains have been installed, with feed grinders, and a cement floor which is kept scrupulously clean. The herd is inspected every year by an authorized veterinarian and kept free from tuberculosis or any other disease.

Much the same situation had to be met with regard to poultry and eggs. It was handled in the same way. A chickenhouse was built in which there are today some 600 chickens. It is kept clean with running water which comes out of the ground at

a temperature of about 80° F. Three men are employed to look after the farming, the dairy and chickens.

Adjacent to the hospital are twenty acres of rich soil irrigated by means of one artesian well with a three-inch finish and a pressure of seventy pounds to the square inch. A new well is also being drilled so that this tract of land with the lawns which comprise about seven acres may be assured an adequate water supply.

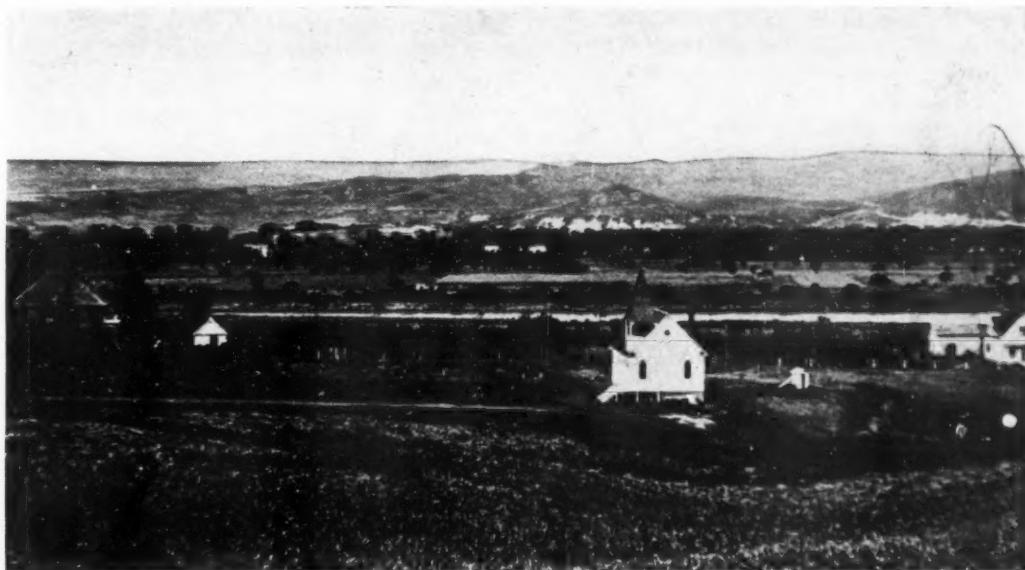
All the vegetables which the hospital requires are grown on the property. This means that there is an ample supply for an average of about eighty people including help, nurses, and patients. In addition to an abundance of fresh vegetables during the summer, a sufficient supply is provided for

about half the exhaust steam the other six months for heating the steam mangle and the hot water, and for canning and steam treatments, we save an average of \$5,000 a year over what we paid out for electricity and power previously.

"We use a coal which costs us at the mines eighty-five cents. We use this in stokers which saves us about \$3.50 a ton on coal that was used before we installed stokers. The coal bill when we bought the electricity cost an average of \$5,600 a year. Since using the cheap coal we pay out about \$4,000 for coal, so we save the entire cost of electricity and about \$1,600 on the cost of coal as it was before we put in our own power plant."

These are affirmative answers to the question of whether a hospital of this type may be made self-

Fertile fields and meadows slope down to the shores of the Missouri River and wheat fields stretch far into the distance.



winter use by canning tomatoes, spinach, beets, carrots, beans, sweet corn, asparagus and peas, and when fruit is cheap, any kind that happens to be on the market. A special steam pressure cooker is provided for this purpose and the services of three or four helpers are required for canning.

The hospital even has its own mill in which it grinds the wheat, making wholewheat flour. This will grind about two hundred-weight an hour and one of the three engineers grinds this when needed. Very little white flour is used.

Electricity, it was discovered, was costing from 5 to 11 cents per kilowatt with the monthly bill for electricity alone totaling about \$400. Again the hospital took the matter in its own hands.

"The exhaust steam from the steam engines we use to heat the buildings during the cold months," Doctor Farnsworth explains, "and as it takes all the exhaust to heat these buildings, the electricity costs us practically nothing except for cylinder oil for six months in the year. As we have use for

supporting, every one of them. Yet in each is reflected the dauntless spirit of the frontier. "No great amount of ready cash on hand, but no bills are outstanding over twenty days. Yes, and when we do raise a crop and the farmers can get a fair price for their produce, we can then perhaps get a fund ahead for the next emergency."

One other item of interest which all hospital executives experiencing difficulty in handling requests for information from friends and relatives on the condition of patients are urged to note. Every noon a broadcast is made of the condition of all patients whose friends are anxious to be informed. This service is rendered because of the fact that so many people live long distances from town with uncertain mail and telephone facilities. The information comes over station WNAX of Yankton, S. D., and is sponsored by a local drug company. Those who have radio sets can relay the information to others who may be anxious to follow the day to day progress of the patient.

Someone Has Asked—

Who Should Appoint the Courtesy Staff?

During the past few years the courtesy staff in the average general hospital has been unreasonably enlarged with the hope that the hospital's income will thus be increased. Ethical and scientific standards have been lowered and physicians who at one time would not have been permitted to practice in the hospital are now observed in its corridors, rooms and clinics.

The granting of permission to practice in the hospital has become in most instances a mere formality. Hospital directors have failed to realize that by permitting this situation to develop they have in reality so cheapened the value of staff appointments that in the future it may be difficult to secure applications for these places from outstanding men. When physicians of low standards thus secure the recognition of the hospital the public concludes that the institution generally approves of the traits which the appointee possesses.

The courtesy staff should be appointed only after the most thorough investigation, since those positions which are most difficult to secure are usually most eagerly sought. When there is no medical administrative officer recommendations are often made by the qualifications committee of the staff with the approval of the board. When there is a medical officer he is perhaps in the best position to judge whether a given physician will prove an asset or a liability. He can seek information from any source he may select concerning such applicants. He may require the approval of a staff committee. But in the end he is held responsible by the board of trustees for the selection of the courtesy staff and for the work it performs.

Under an Eight-Hour Day Should Nurses' Salaries Be Reduced?

The answer to this question in 1935 cannot be the same as one that might have been given a half decade ago. In almost every hospital it has been found necessary to reduce the recompense of nurses substantially. In some instances this has been done to a degree which is even now unfair to the nurse and

beyond which it would be unjust to go.

While **THE MODERN HOSPITAL** cannot record an opinion that in every instance an eight-hour day should be adopted for nurses, yet the trend in the professions and in industry is toward the shortening of hours of labor. Perhaps it is unfair to expect an institution not conducted for profit to meet all conditions imposed upon industry. No doubt in not a few hospitals wages formerly were too high or it has not been found necessary to reduce a satisfactory wage scale. When such conditions prevail, perhaps, a proportionate reduction in salary might accompany the adoption of an eight-hour day.

By and large, however, it would seem unfair to reduce a salary scale that is already too low simply because a reasonable working period has been adopted. The change to an eight-hour day should not be used as a subterfuge to reduce the salaries of nurses.

Should Pediatrician Serve All Patients in His Department?

Most pediatric departments admit children not only for medical care but for general surgical and specialty treatment as well. In many instances even though a surgical state exists the medical treatment is of more importance than the surgical.

In some hospitals young children do not receive the best of care because too close a line is drawn separating medical from surgical conditions. Moreover, consultation service is not always satisfactory because the specialist, having examined the case and inscribed his opinion upon the chart, fails to consider that his obligation to the patient is a continuing one and hence does not return to the pediatric department unless again summoned by the referring doctor. It is not uncommon to observe an undernourished child endeavoring to heal a surgical wound when his chief need is alteration of diet.

THE MODERN HOSPITAL believes that every patient admitted to the pediatric department should come under the ob-

servation of a pediatrician and that while in frank surgical cases this physician may serve only as a continuing consultant, yet his presence at the child's bedside should be frequent and his attention most detailed. When the laryngologist deems it necessary to puncture an ear drum he should continue to visit the child until the condition has been relieved.

It therefore seems that the pediatrician should more often serve in the capacity of family physician to all children in this department and the surgeon and other specialists should more frequently act in the rôle of consultants. When a division of a service into specialties is too rigidly carried out a lack of continued interest on the part of any group is often noticed. The average surgeon is not skilled in recognizing conditions in children other than surgical.

May a Staff Man Refer an Out-Patient to His Office?

This question comes from an executive of a midwestern hospital in which a staff surgeon was discovered sending an out-patient to his own office for dressings. The physician in question was dropped from the hospital staff but is pressing his case for reinstatement. It is rightfully considered unethical for a physician to benefit financially from a dispensary service. Hence most good hospitals strictly forbid the reference of dispensary patients to the offices of clinic physicians.

But before any drastic disciplinary action is taken for such an offense, a careful examination of all the facts in the case should be made. Sometimes an interesting group of cases is being studied by a physician. Or perhaps some unusual treatment or scientific observation is being carried out that warrants more frequent or prolonged study than is possible in dispensary hours and for which the physician makes no charge. These are exceptional cases but they do occur.

When such a situation arises the ethical method of procedure is for the physician openly to request approval of his plan from the medical executive committee of the hospital staff. This being done, no physician could be justly accused of unfair dealing.

If you have any questions to ask, the Editor will be glad to discuss them in a forthcoming issue

Health Hazards in Plumbing

By HERMAN N. BUNDESEN, M.D.

President, Chicago Board of Health

ATENTION has been focused recently upon amebic dysentery by the widespread outbreak centering in two Chicago hotels during 1933. Hospital authorities are greatly interested in this experience because a hospital has much in common with a hotel. Health hazards, like those which caused the outbreak of amebic dysentery, may exist in many hospitals throughout the country, unknown to those in responsible charge, and a similar outbreak of water-borne disease may occur whenever conditions are suitable.

A careful investigation seems to indicate that the 1933 outbreak was caused by contamination of drinking water by sewage through faulty plumbing. In a subsequent article, to appear soon in this magazine, details of many kinds of plumbing defects will be given. Let it suffice here to point out that great pains are being taken by municipalities to purify the public water supply in order to prevent the spread of water-borne diseases. Immense sums of money are spent for the construction and operation of filtration plants, chlorinating apparatus and other means of water purification. As a result of this meticulous supervision, public water supplies as delivered into the street mains at the pumping stations are practically always safe in the cities of this country. Experience has shown that far too frequently these efforts to supply pure water are offset by the contamination of water through cross connections and plumbing defects in the distribution system in streets or buildings.

By the term "cross connection" is meant any connection to a water pipe or fixture through which the pure water may be contaminated by impure water or sewage. Many types of cross connections are recognized by sanitary engineers.

For many years a considerable amount of attention has been given to cross connections in the distribution systems within the streets. It has only been within the last decade that much attention has been paid to similar hazards within the buildings, particularly where there are no auxiliary sources of water supply.

Pioneer work in this field was done by Major Joel I. Connolly of the Chicago Board of Health in

packing plants in 1925, and in hospitals in 1928, when he demonstrated conclusively to a group of hospital and health authorities on April 1, 1928, that contamination of both the drinking water and the sterilized water in hospital operating rooms could easily occur, and doubtless does occur, through improper plumbing connections. This was the first thorough study of the relation of plumbing to postoperative infections and their prevention. The public health engineering profession should give due recognition for this accomplishment and for the saving of human life resulting from it.

Explosive outbreaks of postoperative infections occur from time to time in hospitals involving patients of various surgeons. They point to the contamination of some substance or material employed in connection with the operation, which is common to a number of patients. These explosive outbreaks of infections have long been the subject of careful study, but it was not until after the announcement of the Chicago discoveries in 1928 that the importance of contamination of the sterilized water in causing them became generally recognized.

Major Connolly pointed out that water in an instrument sterilizer or in a water-closet or bedpan washer might be siphoned into the water supply pipes during temporary periods of low pressure. This he demonstrated by means of dye placed in an instrument sterilizer. The pressure in the water

pipe was reduced by drawing water at several locations on lower floors, then the filling connection to the instrument sterilizer was opened. Instead of having water enter the sterilizer, such water as was already in it, colored red by the dye, immediately ran

back into the water supply pipe.

After some time had elapsed, the entire water supply of the hospital was tinged with red, indicating the extent to which the dye traveled from the sterilizer through the water pipes. Wherever the dye appeared at the faucets, drinking fountains or in kitchens, it was apparent that disease germs, such as pus organisms and other infective material upon instruments or pus basins placed in the sterilizer, could also be carried by the water. Infection

of the domestic water supply in this manner might cause stomach or intestinal diseases, sore throats, abscesses of the breast in nursing mothers and other ailments.

Then it was pointed out by Major Connolly that if the inlet valves to water sterilizers should leak, water subject to this dangerous contamination might leak through these defective valves into the sterilized water. The ease with which this might occur was demonstrated by cracking open a valve on the filling pipe to the sterile water containers, permitting a slow leakage into the sterilized water to an extent which would be ordinarily imperceptible upon the gauge glass of the container. In a short time the red color of the dye placed in the instrument sterilizer appeared in the sterilized water drawn from the container, thereby illustrating how readily infective organisms could be carried from one patient to many others. The results of these far-reaching investigations were announced in May, 1928, at the annual meeting in Chicago of the Illinois Medical Society.

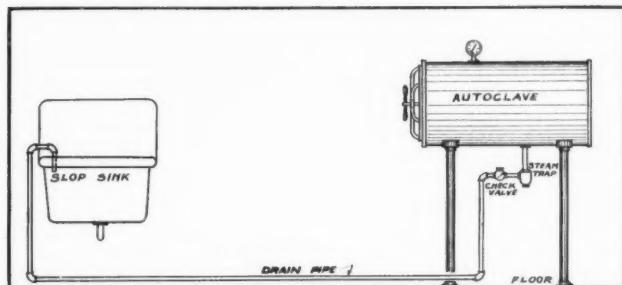
Our experience in Chicago indicates that practically every water sterilizer of conventional type, except those manufactured or remodeled within the past few years, is so constructed that unsterilized water may enter the sterilized water tanks without the knowledge of the hospital authorities. We have, at times, collected samples of water from sterilized water taps in hospital operating rooms and found them to be unsterile. We have even found direct cross connections not only between sterile and unsterile water pipes or containers, but (what is still more dangerous) between sterilized water containers and sewers, which may under suitable conditions cause pollution of the sterilized water. Details of these conditions will be given in another article. It should be obvious that such conditions are potentially hazardous from the standpoint of postoperative infections.

What Happened in Chicago

A recent occurrence in a Chicago hospital may be of interest in illustrating the possibilities of trouble from improper plumbing. A short time ago several babies died at about the same time in one of our large hospitals. Various causes of death were given upon the death certificates but from the unusual number of deaths occurring in one institution at the same time, it looked as though there might be some common cause. I ordered an investigation which revealed that all of the babies who had died at this time had suffered from a diarrheal condition and that they were all bottle fed. The diarrhea suggested to me the possibility of faulty plumbing, and an investigation was made of the plumbing in and around the babies' nursery.

The sanitary engineers noticed that there was a pan, partly filled with water, upon the floor underneath the door of an autoclave in which the babies' bottles were supposed to be sterilized. The presence of this pan made them suspect that there was some unusual condition about the sterilizer. They looked at the instrument to determine, if possible, why it was necessary to use this pan.

It was found that two things were radically wrong with this autoclave. First, the steam pressure gauge registered about six pounds pressure when the door was open and therefore no pressure could exist within the autoclave. The attendant in using this device was making no allowance for the obviously incorrect readings of the gauge. When-



Improper drain connection, permitting siphonage of waste into autoclave used for sterilizing nursing bottles.

ever a gauge fails to return to zero under atmospheric pressure conditions, or in any other way appears to be out of order, it should be repaired and recalibrated immediately so that the operator of the autoclave may have some idea of what he or she is actually doing. Second, this autoclave was found to have a drain leading along the floor to a slop sink in another room. Upon this drain there was a steam trap and a check valve. For most of its length this drain was constantly filled with sewage, inasmuch as its outlet at the slop sink as shown in the accompanying diagram was about two feet higher than the greater part of the drain itself.

It is well known that when steam condenses within an enclosed chamber or vessel a vacuum is formed. This is the fundamental basis of the design of all condensing steam engines. The vacuum produced in the autoclave by the condensation of steam, when sterilization of the nursing bottles was finished, sucked approximately 300 c.c. of sewage out of the drain pipe into the autoclave, contaminating not only the sterilized nursing bottles therein, but also the hands of the attendant when she opened the autoclave door and the sewage ran out into the pan on the floor.

The attendant then filled the nursing bottles with milk for the recently born babies in the hospital nursery. This, in itself, would have been bad enough, but it is not all. It was as if this drain had been designed by some sinister influence to make

it as hazardous as possible to the babies, because it not only terminated at a slop sink where various kinds of materials were thrown away, doubtless including a certain amount of fecal material, but the end of the drain pipe from the autoclave actually extended down into the sink. Therefore whenever the outlet to the slop sink became stopped up, as frequently happens with this type of fixture, due to the kind of materials thrown into it, the end of the autoclave drain would naturally become submerged in the highly contaminated contents of the sink.

Then the siphoning action produced by condensation of steam in the autoclave would suck somewhat more than half a pint of this very dangerous material out of the slop sink into the drain pipe of the autoclave where it would contaminate all the water which constantly stood in the drain. From that time on, every time the autoclave was used, some of these slop sink contents would reach the sterilized nursing bottles in the autoclave.

The Autoclave Is Proved Guilty

Suspecting that this condition of the autoclave was the cause of the deaths, I ordered this condition corrected immediately. Certain other improvements in the care of babies in this hospital were also ordered. There has been no extensive mortality among babies in this hospital since that time.

This incident illustrates the necessity for intelligent design and installation of hospital plumbing if well people in hospitals are not to become sick and if sick people are not to become sicker, by superimposing other maladies upon those from which the patients suffer when they enter the institution. It is our belief, based upon our own observations made in Chicago, and in a number of other cities, scattered from coast to coast, that the hazards to health in hospitals, through improper plumbing and dangerously installed sterilized water containers, are of nationwide importance. These matters merit the careful consideration of every hospital superintendent and surgeon.

The American public is becoming conscious, as never before, of the hazards to health involved in unsafe water supplies and is demanding in no uncertain terms that hotels in particular clean house.

Several national organizations and many state and local organizations are requiring hotels in which they propose to hold meetings to secure from the health authorities certificates that their plumbing has been recently examined and found to be safe. This demand for safe plumbing in hotels, recently evidenced by the public, is now being extended to include hospitals, office buildings and other types of structures.

Another factor to be considered is corrosion of waste pipes in older buildings. Pipes of steel and iron are subject to rust and electrolysis from stray electric currents. Where brine is used in the ice plant of a hospital, corrosion is promoted by leakage of brine upon sewer pipes of ferrous metals.

Wherever sewers are suspended from ceilings, as is frequently done in basements, in order to keep them above the level of the street sewer, there is the possibility that in the course of time they may become corroded and leak. If the leaking sewage drips unnoticed upon ice cream, lettuce and other foods eaten raw, or even upon cooked foods after they are prepared, in kitchens, ice boxes, or on food en route to the rooms of patients, it is easy to see how intestinal diseases such as typhoid fever may be spread. Also, if leaky sewers pass over uncovered tanks used for storage or cooling of water or for storage of ice used in drinks, there is a similar possibility of disease transmission.

Experiments have shown that the cysts of *Endameba histolytica* die quickly after drying, but may live in water for months. Therefore sewage contamination of drinking water, through cross connections or by reason of leaks in sewers over water tanks, may well lead to outbreaks of amebic dysentery.

Another important consideration is the hazard presented by water operated fixtures such as aspirators. There are two sides to this problem, the protection of the patient being operated upon, and the safeguarding of the water supply from contamination through such devices. These factors will be dealt with in more detail later.

A Dramatic Incident

An unusual example of a hazard in a plumbing system, probably unique in hospital history, occurred in Chicago a few years ago. A new hospital had just been completed, invitations to many illustrious officials, physicians and other citizens had been sent out, and all seemed set for the grand opening ceremonies. Then an explosion occurred in the drainage pipes of the building, blowing the water from the traps of the fixtures all over the ceilings and causing consternation among the occupants who were busily putting on the final touches. The building department of the city immediately refused to permit the hospital to open its doors.

Then the board of health was requested by the hospital authorities to lend its aid. We found that gasoline leaking from tanks in a garage across an alley from the hospital was entering the underdrains around the foundation walls. As it was warmed by the heat in the building, part of the gasoline vaporized, filling the pipes with an explosive mixture somewhat similar to that which one

gets in an automobile engine. Then all that was necessary was something to touch it off, such as using a blow torch on a pipe, and the explosion occurred.

We put a test upon the gasoline tanks and pipes in the garage, found which were defective and filled them with water instead of gasoline. This cut off the source of the flow, but there was enough gasoline in the ground, floating in a pool on top of the ground water under the garage, to continue the hazard to the hospital for a long time. To counteract this and permit the hospital to open as scheduled, we recommended sinking a well in the alley between the hospital and garage to intercept the flow of gasoline through the ground before it reached the hospital drains. This was done and the trouble was cured.

In my opinion every large hospital should have upon its staff a competent sanitary expert to supervise the water supply and waste disposal, sanitation in kitchens, sterilization of dishes and silverware after each use and before further use, sterility of water and other things used in surgical operations. Because of the vast number of people

passing through a large hospital in the course of a year, the sanitary conditions may affect the health of a number equal to the population of a fair sized city. Just as a city should have its health officer, a hospital should have its sanitary expert.

Smaller places may be able to employ a sanitary expert to supervise the health protection of guests, patrons and employees, by having several share the cost. These smaller places need his services just as much as the large ones. Another safeguard is to have all plumbing installations and remodeling done by a licensed master plumber who is acquainted with the danger of improper installations and lives up to his responsibilities. Many dangerous connections have been made by persons who are not plumbers and who did not recognize the dangers incurred as the result of their activities.

Few, if any, cities have sufficient personnel in their boards of health to give adequate inspection to all places in the city, and it is the responsibility of the management of hospitals to supply such supervision as may be needed to assure that the hazards to health I have mentioned, and others as well, are eliminated and prevented.

Hospital's Liability for Neglect in Selecting Employees

What is the liability of charitable hospitals for neglect in selecting employees? The opinion of the Supreme Court of Appeals of Virginia regarding this matter, as reported in the *Journal of the American Medical Association*, is given below:

The appellee, a pay patient in the appellant hospital, a charitable institution, was injured by reason of the negligence of a hospital nurse in giving the patient a vaginal douche. The trial court gave judgment for the appellee and the hospital appealed to the Supreme Court of Appeals of Virginia.

The liability of a charitable hospital for negligent acts of its servants, said the Supreme Court of Appeals, was settled in Virginia in the case of *Weston's Adm'x vs. Hospital of St. Vincent, etc.*, 131 Va. 587, 107 S. E. 785, 23 A. L. R. 907. In that case, the court held that the only duty which a charitable hospital owed to its patients was the exercise of due care in the selection and retention of its servants. In the present case, continued the court, there was no question that the jury was justified in concluding that the negligence of the nurse was the proximate cause of the patient's injuries.

The superintendent of nurses testified that, in selecting a nurse, one of the requirements was that the applicant should have had three years of high school work. The evidence showed that the nurse responsible for the patient's injuries had never attended high school and that she had attained only the tenth grade in a graded school. During the three years that she had been in the hospital, she had been repeatedly reprimanded for infractions of the rules of the hospital, had been threatened with dismissal and

had been retained only because the superintendent felt sorry for her.

It is not sufficient to say, according to the Supreme Court of Appeals, that a nurse is competent simply because she is capable of discharging the manual duties incumbent on her as a nurse. It is a matter of common knowledge that the welfare of a patient is as much the responsibility of the nurse as it is of the physician. If the nurse is lacking in educational preparation, if she is guilty of indiscretions that impair her physical or mental status, if she is lacking in that moral character which imbues the patient with confidence, then it cannot be said that she is a competent person to be placed in charge of a helpless patient.

The finding of the trial court that the hospital was negligent in the selection and retention of the nurse was amply justified by the evidence, the court concluded, and the judgment against the hospital was affirmed.—*Norfolk Protestant Hospital, vs. Plunkett (Va.)*, 173 S. E. 363.

Occupancy Low in Small Hospitals

Occupancy in small hospitals is much lower than in larger hospitals to judge by figures published in the latest annual report of the Duke Endowment. In a presentation of data from 154 general hospitals in the Carolinas, not all of which are aided by the foundation, the following occupancy figures were given:

Size of Hospital	Number of Hospitals	Occupancy Percentage
Over 99 beds	19	61.2
75 to 99 beds	9	52.8
50 to 74 beds	29	48.0
25 to 49 beds	69	44.4
Under 25 beds	28	35.4

Why the State Should Support Schools of Nursing

By ETHEL J. ODEGARD

Educational Director, School of Nursing, Miami Valley Hospital, Dayton, Ohio

EVERYONE is familiar with the struggle that has been made for the education of the nurse during the past fifty years. The advances made in her education have not been made from a desire to meet the educational needs of a profession but rather with a view to aiding the hospital.

The development of the school of nursing within the hospital has prevented the public from knowing the needs and requirements of schools of nursing as educational institutions. The public has heard the demands of hospitals for money for building projects and for equipment. The directors of the schools, being also the administrators of the nursing service of the hospital, have been forced to subordinate nursing school problems to those of general hospital administration. For this reason the public has not grasped the problem.

The Public Is Uninformed

It has apparently never occurred to the public that the education of the nurse should be assumed by an educational institution rather than being a service institution in the hospital. The public while criticizing the system of nurse training still believes that the entire responsibility for this training lies with the hospital authorities and that educational institutions need have no concern with it. There is a similarity between the situation of nursing education today and that of medical education some decades ago. Dr. Henry S. Pritchett in his report to the Carnegie Foundation points out that medical training is an educational matter rather than a professional problem. He says further that professional education in this country has suffered because of the notion that to train a man for his profession, one must have the viewpoint of the practitioner only and not the viewpoint of the teacher as well.

In nursing education it has generally been thought that the viewpoint of hospital administrators should govern the situation. When the nurse, therefore, with the narrow preparation that she has received in the hospital, has entered the professional field outside the hospital walls, she has been criticized because her hospital education was

inadequate. Her education has been such that it has neither qualified her to measure up to community standards as a public worker, nor developed her potentialities as a nurse. Her training has been directed almost entirely toward making her of the utmost use to the hospital regardless of her individual development or her appreciation and knowledge of the community aspect of her work. Then when difficulties arise the public has directed its criticism against the individual nurse instead of against the institution of which she is a product.

Professional education is primarily for the development of the individual and should be conducted from that point of view and not from a consideration of the amount of service that may be rendered during the educational period.

The basic principle underlying any program of public financial support in education is that whatever is for the good of the people as a whole should likewise be supported by the people as a whole. In this respect we know that one of the motives for state participation in education is the desire of society to secure the safety of the social group. So far as teaching is concerned it is held that unless a level of general intelligence can be maintained, the safety of the state will be endangered.

In analyzing the reasons why nursing education merits state support we find two important ones: first, the value of the service to the community and second, the development of the individual.

The Nurse Has a Public Duty

One of the most important services the nurse renders is that of teaching the public in matters concerning health and social welfare. This undoubtedly has fallen primarily to the public health nurse but all nurses share in this function.

The Goldmark Report on "Nursing and Nursing Education in the United States," published in 1923, states that "Major health problems of the present day, such as the control of infant mortality and tuberculosis can be solved only through personal hygiene — an alteration in the daily habits of the individual. . . Such changes in the daily habits of the people and in their relation to the medical ad-

visers can be accomplished by but one means — education. . . . We have sought during the past twenty years for a missionary to carry the message of health into each individual home; and in America we have found this messenger of health in the public health nurse."

Nursing in its various branches of public service is undoubtedly evincing its right to state support on the grounds of social usefulness. One has only to read the literature on the administration of public schools in order to see the increasingly important part the nurse is assuming in the maintenance of the health of the school children.

Preventive Work Is Far-Reaching

In industry the teaching function of the nurse is as important as her first aid work. To be sure she does assist in reducing handicaps as a result of industrial injuries but it is her work in the prevention of disease which is the most important and the most far-reaching. The objective of medical and nursing service in industry is to improve health and decrease disability in order to increase production. The industrial nurse furthers this objective by making a large contribution to the anti-tuberculosis program. Her work is primarily with the adult group in which is found the highest mortality rate of this disease.

The possession by the nurse of certain knowledge and skills is an invaluable protection for the community. This knowledge may be considered as being a quality entirely separate from the quality of teaching. In this respect may be mentioned the knowledge of bacteriologic laws and procedures necessary to protect the public against the spread of communicable diseases and to reduce infant mortality and the maternal death rate.

Finally, aside from teaching the public and from possessing skills and knowledge valuable for the public safety, there is certain necessary work for which the community depends upon the nurse. This consists of the administration of the nursing service of hospitals in urban and rural communities, administration of clinics and dispensaries, of public health nursing associations and of first aid departments in department stores, theaters and other public institutions. More important than any other service though mentioned last is the actual nursing care given to all types of patients.

The work, then, of the members of the nursing profession stands as evidence why the state should develop and support schools of nursing which would give the students a preparation adequate to meet the social need. If these schools are essential to the welfare of the state as a whole, then their support should be by the general taxation of all.

The second reason for urging financial assistance

to support a right program of nursing education is the development of the individual. Professional candidates of medicine, law, social work and teaching, by virtue of attending educational institutions, are looked upon as students learning the art and science of their professions. The student nurse who is continuing her education in a hospital school is not looked upon as a student but as an employee. While this may develop her sense of responsibility it also discourages the development of other desirable qualities.

While the nurse is in training her physical endurance is subjected to unreasonable strain. Nurse leaders have fought to reduce the hours of service which hospitals could demand and which the public has allowed. Is it to be wondered at that in the second and third year of training the nurse begins to change from the idealistic, enthusiastic, willing and interested high school graduate to a listless, indifferent, extremely fatigued young girl? This attitude has become established by the time she receives her diploma. We should be thankful that after they have been away from the régime of hospital life for a few years some nurses again regain a normal attitude.

Why should such a decline in interest take place in this group of students when amongst other students there is a steady growth of interest and enthusiasm from year to year? The answer is that in educational institutions all the attention is directed to the development of the minds and the unfolding of the personalities of the students. In the hospital the mental alertness of the student has been dulled because of the constant repetition of tasks that have long ceased to be educational.

Has Not the Nurse a Claim on the State?

It seems only logical that the state which has been concerned with the development of these young women through their four years of high school should continue this interest through the period of professional nurse training and offer the same opportunities to the girl who wishes to be a nurse as it does to the girl who wishes to be a teacher. Not until schools of nursing are controlled by educational institutions which have as their primary object the education and development of the individual will society have the type of graduate nurse which it expects to have. The usefulness of the nurse will increase in proportion to the amount that society is willing to spend for her education.

The report of the National Committee for the Grading of Nursing Schools states that hospitals should not be expected to pay for the cost of nursing education out of their incomes but that nursing education should be supported either by private or by public funds.

In some cities where schools of nursing have an established reputation, efforts to secure funds from private sources would probably be successful. In the majority of cities, however, neither the conditions of established reputation of schools nor private resources are available. If one individual school of nursing secures an endowment from private funds it eliminates other schools in the same city from benefiting from this financial assistance. This is assuming that no city of moderate size has private sources capable of giving more than one large endowment. Such an endowment will give that school an unfair advantage over other schools in the vicinity which may have equal right to financial support. These schools may also be able to make a valuable clinical contribution to nursing education. To circumvent such an occurrence all schools in that city might unite as a central school to obtain a private endowment.

Professional Associations to the Rescue

The other method for obtaining financial assistance, and in my opinion the better one, is for the professional nurse organization, the state nurses' association, with the assistance of the state hospital association, to obtain state funds for a limited number of schools throughout the state. If members of the nursing profession are to accept concretely the report of the grading committee then the local and state professional organizations must make a concerted effort to obtain public funds for their schools of nursing.

A definite plan should be formulated, in which it will be decided where the centers of nurse education are to be situated. Some years ago I recommended that schools of nursing be assisted in the development of their educational resources by the state teachers' colleges found in most states. My

feeling on that point has become much stronger in the last few years.

While teachers' colleges are primarily for training teachers for the public schools, they are increasingly offering preprofessional training and other courses in the practical arts. Almost all of these schools have basic courses that nurses require. A survey of any one of their bulletins will show courses in anatomy, physiology, hygiene, bacteriology, chemistry, psychology and sociology. It would not be a great problem or expense to set up the other courses that are needed in the nursing curriculum.

An arrangement such as this could be made temporarily with the colleges cooperating with the local schools of nursing in promoting an educational program. In due time when legislation could be procured the colleges should assume the educational responsibility for the nursing schools.

This program would mean that there would be established in the community one school of nursing that would conform to the best standards found amongst our schools today and would also establish an improved educational program such as exists nowhere. The clinical hospital experience would be given in those hospitals in the city and environs which offered the necessary experience to student nurses. Furthermore, this experience would be determined according to the educational value it would have for the student nurse and not for the service value that it would give to any hospital. The school would be directed by a state educational institution with the addition of a local advisory board with adequate nurse representation. This arrangement would also involve payment by the student of small tuition and incidental fees as well as of maintenance during the period she was devoting her entire time to work in the classroom.

Hospital Personnel That Are a Liability

Charles E. Findlay, superintendent, Butterworth Hospital, Grand Rapids, Mich., makes this good suggestion:

"I feel that we should encourage journal clubs for hospital personnel and rotate the leaders in the discussions by having all departments of the hospital represented. There is so much valuable material in hospital journals today that should be made available to every member of the hospital personnel. If we educated our personnel in this way, we should not have so many unqualified hospital administrators."

"A hospital may be considered a temporary home for the sick and injured and it should be made just as homelike as possible. We are servants of the public and we all know that the public demands efficient and especially courteous service. Many patients leave hospitals feeling unkindly

toward the institution because of a discourteous remark made to them by an inefficient member of the hospital personnel or because of lack of attention when it is most needed. Yet we retain the services of these unqualified members of our personnel out of sympathy because they have been with the institution a number of years. They have never been sufficiently interested in their work to read a hospital journal or to visit a progressive hospital."

The Well Dressed Employee

The uniforming of hospital personnel having contact with the public, other than nurses, has become a generally accepted practice. W. Mezger, superintendent, Knickerbocker Hospital, New York City, contends, however, that a poorly maintained uniform is conspicuous. He suggests an inspection schedule and washing, pressing and mending as needed.

Editorials

Public Funds for Medical Research

If Commissioner Goldwater has his way, the public hospitals of New York City will go into friendly competition with the voluntary hospitals in the research field. The metropolitan press carried an interesting release from the Department of Hospitals of New York City on February 24, telling the world about this "New Deal" in investigative medicine. What are we coming to?

Up till now interest in medical research has been one of the special characteristics of the voluntary hospital, and not alone of those voluntary hospitals which are organized on a teaching or research basis in association with medical schools. Patients who seem to present clinical problems for investigation, especially those whose illness is of short duration, come under the "interesting" classification and receive a special welcome in voluntary hospitals generally. Most of the other patients, whose qualifications are not so clear, are referred either immediately or shortly after admission to public hospitals where the taxpayer is expected to look after them as best he can, without the stimulating help of a visiting staff whose educational and investigative talents are encouraged.

As in the case of applicants for admission, so it is with the policies governing the selection of the visiting staff of the voluntary hospital. Those men are preferred and encouraged who, in addition to ability along routine lines, have teaching capacity and clinical originality. A canvass of the visiting medical staffs of voluntary and public hospitals in the United States will show that the leaders in various fields of clinical endeavor are much more frequently associated with voluntary than with public hospitals. One of the reasons for this is that the voluntary hospital offers better opportunities to the physician with the investigative turn of mind than the public hospital does which will spend money for medical necessities only and, as a result, be wasteful of the by-products.

Commissioner Goldwater's plan will in the end yield greater dividends for the taxpayer, and increase public confidence in municipal hospitals, inasmuch as clinical waste will be reduced to a minimum, while the by-products will be vigorously studied and used for successive generations of sick people. This is as it should be. If the taxpayer can be made to see the light and adopt this plan he will

remove with one stroke an important barrier between the public and the voluntary hospital and bring them closer together in their service to the community.

One per cent of the routine budget for research purposes, which is the figure that Commissioner Goldwater quotes in his plea to the public, seems altogether reasonable. More power to him and to those who support this historic move for hospital progress.

Depression Remnants

PRICE consciousness and sales resistance are two traits which really imply on the part of the executive a fear to buy rather than a lack of need for hospital goods.

All who boast of any degree of business sense compare quality with cost before signing an order. He who is sensitized to price looks long at the price tag and but casually at the finer points of the article. This attitude is a remnant of past financial frights. Sales resistance is also a defense mechanism on the part of the executive who during the past few years did not dare to buy because he knew not how to secure money to pay.

Often these two traits in an otherwise tactful administrator bring about the most discourteous reception of really trustworthy hospital supply salesmen. Such an attitude on the part of the executive is neither polite nor profitable. Much may be learned from the seasoned drug, food or instrument salesman, who merits at least a civil hearing.

Public Relations and National Hospital Day

NATIONAL Hospital Day offers an unusual opportunity for the hospital to obtain a cross section of the public's attitude. When scores and hundreds of guests are passing through your hospital on National Hospital Day why not in some way ascertain and record their attitudes toward the hospital, their suggestions for improvement or extension of its service, and their proposals for meeting the cost of hospital operation? Perhaps they could each be given a brief questionnaire to fill out. Or they might be asked to register and a letter sent to each of them within a day or two. Or the personnel of the hospital could be asked to talk with the guests and make written reports.

The service which a hospital can render and the

support which it receives depend in large measure upon how well the physicians and the public in the hospital's service area understand its functions and its problems. In all parts of the country both governmental and nongovernmental hospitals are realizing more fully the vital importance of their relations to the public.

Sound public relations must be built on merit. Without true service there can be no sound and enduring public confidence. But merit alone is not enough. The hospital cannot hide its light under a bushel, but must, in a dignified and effective way, portray the place it occupies in the good life of the community. This does not mean vainglorious boasting, overemphasis on the bizarre or freakish, or claims of highly superior virtue or ability. It does mean that the hospital shall constantly be sensitive to the needs and desires of its community even before these needs and desires are presented in carefully formulated fashion. It means that the hospital must take every reasonable step in its power to meet the needs and desires of its service area. Finally, it must tell its public what has been done and, if appropriate, outline what more it might do for the benefit of the community if increased funds were available.

If National Hospital Day means only a baby show with refreshments, it may hardly be worth the trouble. If, on the other hand, it is made the occasion for more fully taking the public into partnership it can well mark a real milestone in any hospital's life.

Counter Prescribing at Its Worst

THE manufacture and sale of corrective surgical appliances is one of the worst spots in medical practice today. Anyone, whether trained or not, may set himself up as a manufacturer or retailer of these goods. Department stores and mail order houses, for example, are large sellers of trusses and supporters, the patient as a rule attempting to fit himself. The business as a whole is almost entirely without medical supervision, it reeks with fee splitting and is a threat to the health as well as the pocketbooks of patients who need braces, trusses, surgical appliances or corrective corsets or shoes.

An attempt to control the fee splitting aspect was made by the American Surgical Trade Association in the formulation of its NRA code. The MODERN HOSPITAL is reliably informed, however, that the evidence indicates widespread nonenforcement of this clause.

Elsewhere in these pages Miss Dunning, who has had extensive experience in this field as direc-

tor of the out-patient department of the New York Hospital for Joint Diseases, outlines the problem and suggests sane and constructive remedies. The American Medical Association, the American Hospital Association, the American College of Surgeons, the American Surgical Trade Association, and the various groups of specialists in this field could well unite in a campaign to correct the condition so well set forth in the Dunning article. The MODERN HOSPITAL invites their attention to this problem.

Changing Values in Staff Appointments

IN THE strictly closed hospital staff appointments carry as an important perquisite the treatment of many private patients referred by physicians not enjoying hospital privileges. The holder of a hospital chiefship in such an institution is usually a physician of distinction who, among the few honored by the hospital, occupies a place similar to that of the department head in a medical college.

It was the fact that but relatively few community physicians held such hospital places which brought into existence many smaller institutions staffed by surgeons who desired to operate upon their own patients. That many of these hospitals had no real reason for existence, from the patient's standpoint at least, is beside the question. Today there has been a rapid and rather widespread increase in the number of physicians granted medical, surgical and obstetrical privileges in the country's hospitals.

The economic pinch has been the cause for this change. As a result the visiting physician but rarely receives referred patients for hospital treatment and the capable surgeon observes others of less skill and often of low ethical standards operate in institutions which question not at all the right or ability of the applying doctors to perform major surgery. Moreover, such pseudo-surgeons too often it is suspected weigh the necessity for operation as carelessly as they estimate their own ability to perform such hazardous work. A general return to the closed hospital plan is not being urged, but some way must be evolved to enable the public to recognize a safe surgeon from the neophyte or the charlatan with little conscience and less skill.

A good hospital protects its patients from the surgical pretender—a bad one admits its patients for the fees they pay and smugly shrugs institutional shoulders when the abilities of its staff are

mentioned. Without doubt the place of the staff physician has been cheapened by this new open door policy. What is more serious still is the lowering of professional standards which has accompanied this change.

Some way must be found to give staff privileges, with the accompanying discipline and professional stimulus, to all physicians who can safely use such privileges and at the same time fully protect the patients' safety and the hospital's reputation. The experience of the Tacoma General Hospital, reported elsewhere in this issue, is of real interest in this connection.

The Retirement of Staff Physicians

SOME hospitals possess distinguished and experienced staff members, the majority of whom have passed three score years in age. Such institutions have not considered it important to adopt a definite policy of retirement for staff members when a fixed age is reached. Disability because of failing physical powers is in such cases the only criterion indicating the wisdom of retirement.

To follow such a plan is to fail to build for the future and invites sudden and damaging collapse of staff morale. Often a paucity of trained understudies is found in such hospitals because the young physician or surgeon of promise, seeing no hope for advancement, seeks affiliation elsewhere. The retirement age for surgeons is sometimes set at sixty-five and for physicians at sixty-eight. Again the attainment of an age of seventy automatically brings about relinquishment of ward duties.

Whatever the age limit, the adoption of a retirement plan is to be considered as a wise policy for the hospital to decide upon. To place this matter on an individual basis is to court dissatisfaction, suspicion of unfairness and a disruption of morale as each retirement is made effective.

California Moves Toward Health Insurance

IT NOW appears reasonably certain — as certain perhaps as anything dealing with legislation can be — that California will be the first American state to pass a compulsory health insurance bill. If it isn't approved at this session of the legislature, it probably will be favorably received at the next.

The Western Hospital Association has been on

record in favor of such a measure for over a year and reaffirmed its support at the convention in February. More recently the house of delegates of the California Medical Association, the council of the California Dental Association, the California Public Health League and other professional organizations have officially voted to support health insurance that would be compulsory as to certain groups of the population and voluntary as to others. The proposal also has the support of the state federation of labor and the state grange. Interestingly enough this entire movement has been created by California people themselves. No national organization has carried on any special propaganda in California.

It is fortunate that in California the professional organizations have, by their progressive attitude, placed themselves in a position to influence the legislation constructively while it is still in a fluid state. So long as their requests are compatible with the public interest and there is agreement among themselves, there is no reason to suppose that they will be denied. California should be able to develop a bill which will be a model for other states. If so, even Florida may feel indebted.

Must the State Step In?

ONE Sunday evening nearly twenty years ago a youngster was brought into a hospital operating room with his abdomen riddled with gunshot. It was the usual story. Out hunting, he pulled his gun toward him as he crawled through a fence. While the nurses and doctors were working desperately, the lights went out. They scurried around and found candles and lamps. In the semidarkness no one could really see what he was doing. The nurses had to be very chary with the ether and the surgeons could not see the operating field distinctly. The lad died.

Two years ago in that same operating room the doctors were trying to get a sliver of glass out of a boy's brain. He had been hurt in a cyclone. In the midst of this delicate operation, the light again went out. This youngster was more fortunate. He survived even that complication. But the hospital was as unprepared as it had been eighteen years earlier.

Such instances as these have led some states to require all hospitals to have acceptable emergency lighting systems for their operating rooms, exits and certain other strategic places. A state law should be unnecessary, the need is so obvious. If hospitals do not act, however, there is little doubt that legislators will.

The Board's Committees and the Part They Should Play

There is a fine distinction between policy and administration which board subcommittee members must recognize. One belongs to the board of trustees and the other to the superintendent. So long as the balance of power holds, the hospital will be a well run unit serving the patient

THE organization and necessary qualifications of the members composing a hospital board of trustees were discussed in the March issue of *The MODERN HOSPITAL*. It was said that the type of work performed in any institution is largely determined by its board. No reflection was cast on the vision or conscientiousness of those people who generously give their time and effort to the management of the country's hospitals, but an effort was made to draw attention to some of the functions of the trustee in contradistinction to the duties of the superintendent and his staff.

The chief duty of the board is to determine the hospital's policies, and there is a vast difference between policy making and active administration. With rare exceptions, institutional board members have little conception of the practical aspects of hospital administration, for executive work of this type requires long and arduous training. Consequently hospitals are efficient or inefficient in direct proportion to the amount of recognition given by their boards of trustees to the difference between policy making and administration. An attempt on the part of trustees, either individually or collectively, both to formulate and administer policies leads to institutional chaos.

The superintendent is expected to conduct the hospital efficiently, to maintain the confidence and

morale of its lay workers and to handle tactfully a temperamental staff. At the same time he must direct the usually meager funds of the institution in such a way that bills are paid and equipment kept up to date. Aside from this exacting program the executive is often required tactfully to educate those board members who show a tendency to interfere with the administrative work.

Often the greatest problem confronting the hospital superintendent is the need of spurring on a lethargic board or tactfully directing the activities of one which is overinterested. Perhaps the most difficult lesson for a new board member to learn is that all administrative matters must enter and leave the hospital by way of the superintendent.

The tenure of office of the average hospital superintendent is at the best precarious and relatively brief. Students of administration have concluded that in most instances a superintendent changes positions not because of his failure to conduct the affairs of the hospital properly, but rather because of the existence of personal friction with influential board, staff or community members. This unfortunate situation often develops as the result of differences of opinion on matters of administration or in regard to the respective duties of the administrator and the board.

Mutual Agreement Not Always Advisable

The next and final step which must be taken when such a situation arises is the transference into personalities of honest divergencies of personal and professional opinion. Sincere and frankly stated differences of opinion should generate respect and not animosity on the part of either the administrator or his superior officers. It would be well for board members and executives alike to remember that mutual agreement in order to avoid an unpleasant situation does not always render the greatest service to the institution or to its patients.

It is through the activities of subcommittees of the board of trustees that the individual board members are brought in closest contact with hospital work. During the work and deliberations of these committees there frequently originate misunderstandings in respect to the motives and methods of the superintendent. To prevent this a

definite policy as to the functions of board committees should be worked out. It cannot be too forcefully stated that just as the board is a policy making body, so should its committees be largely concerned with matters that are divorced from actual administration.

Committee Should Be Consultant Group

Such committees, working with the superintendent, are able to assist him greatly in the practical application of the mandates of the board as a whole. They may serve as his consultant and advisory group, encouraging and supporting him when it is necessary, and properly representing their activity or department at the meetings of the board proper. Moreover, from a practical standpoint, such a committee should make rounds accompanied by the administrator or one of his representatives. In this way its members are able to learn at first hand the reasons for the existence of various institutional procedures. Moreover, their presence in hospital corridors and wards in company with the superintendent proclaims the board's confidence in the superintendent.

The most important committee of the hospital board is the executive. To this group is delegated the powers of the board and it meets frequently as an active, informed body capable of making decisions for the superintendent if the need arises. The administrator should be an ex officio member of this committee and should be in attendance at its meetings. He is its administrative expert.

This group may check on the work of all other standing committees and thus harmonize and coordinate their activities. It is the executive committee which carefully considers all problems in order that it may possess concrete recommendations to present to the board for final approval or rejection. It is conceded by all that no practice is so useless or so dangerous from an institutional standpoint as that of submitting large problems to a hospital board and hoping that a well considered and practical solution will be forthcoming. This committee may be elected by the board as a whole or it may consist of all the chairmen of the standing committees sitting with the officers of the board as ex officio members.

Most institutions provide in their constitutions for the existence of the following committees in addition to the executive committee: the house committee, the committee on finance and accounts, the medical committee, the committee on the nurses' training school, the property committee, the social service committee, the publicity committee and any number of special committees.

The chief functions of the house committee are to study administrative matters, to discover the

most efficient methods by which the hospital's business may be conducted and to receive and investigate complaints of mismanagement whenever they arise. Most of the business of this committee should originate in the superintendent's office, for a good administrator will recognize the existence of faults long before they are detected by a board member, and he will present them to this committee for its consideration.

If bookkeeping methods are inefficient, the executive should recognize it and request this committee to study the condition and suggest such alterations as are found necessary. The house committee, with the superintendent or at his request, should inspect the housekeeping and furnishings of rooms and residences for the hospital's personnel. It should hold regular meetings and make periodic rounds with the superintendent. It should never consider itself, or be considered by others, a committee expected to spy on its own employees.

The committee on finance and accounts is all important. The matter of securing funds either by drives, benefits or the encouraging of endowments is of vital importance. This committee should submit to the trustees a monthly report of the hospital's financial standing and in conjunction with the superintendent should draw up the yearly budget under which the hospital will function.

Inventorying Intangibles

If a medically trained superintendent directs the hospital, there is less need for the activities of a medical committee than where a nonmedical person supervises the institution. In either instance, however, there is a need for a group which has as its duty the consideration of ways and means of improving medical and surgical service, of outlining methods for staff appointments and of placing on a purely impersonal basis the matter of staff discipline. Each year the efficient hospital takes inventory of its physical property. Much less rarely is a serious attempt made to estimate in the same accurate way the type and effectiveness of the hospital's service. Too careful consideration cannot be given to the qualifications of those applying for staff appointments.

The danger which arises in the functioning of all board committees is inherent in the activities of this one. Reports of derelictions of duty on the part of the staff or of improper medical service generally should not be made first to this committee. They should be received in the office of the superintendent and should be discussed by him with the chairman of the medical committee. If it is the belief of both that the specific complaint warrants its being presented to the committee as a whole, this action should be taken. The origination

of studies and the hearing of complaints without the matter first having been discussed with the superintendent are likely to lead to embarrassing situations.

Each committee chairman should adopt the policy of refusing to consider any matter which has not proceeded through the officially designated officers of the hospital to his group. This is a vital point. The recommendations of the superintendent or of the staff committee on personnel, while always being given serious consideration, need not of course be routinely accepted.

Above all, no medical favoritism should be shown, even though a physician happens to occupy the position of family medical consultant to the chairman or to any of its members. Scientific skill and professional attainments only should secure hospital appointments.

The committee on the nurses' training school is in a position to perform a fine service to the institution. This group cooperates with the superintendent and the directress of nurses in improving recreational and social activities in the hospital's school. It is consulted on serious matters of discipline and represents the cause of the nurse at the meetings of the board proper.

The training school committee could well be headed by an educator whose vision of pedagogic methods and possibilities should make possible outstanding improvements in the methods of instructing the pupil nurse. There seems to be a tendency in the nursing field today for the superintendent of the training school to feel that she requires an avenue of approach to the board of trustees which does not traverse the office of the superintendent of the hospital. This attitude of course is not consonant with the best methods of administration, since no paths for the conduct of routine business should emerge from the hospital except through the office of its administrative head.

Nursing Head Answers to Superintendent

The training school committee like all other committees, should be a policy making body. It should not concern itself with matters in any way administrative. The superintendent of nurses must be held wholly responsible for the conduct of her school and her immediate superior must be the hospital administrator. If this officer is not educationally minded and if he does not realize the requirements necessary for the proper instruction of nurses, then he is not capable of occupying the position to which he has been elected.

It cannot be too strongly stressed, as in the instance of the house committee, that the superintendent of the hospital and of the school for nurses

should present to this committee matters requiring its attention rather than have the reverse be the case. A training school committee that seeks to administer, rather than to advise on broad educational policies, is likely to be a disorganizer and a menace to progress.

The property committee is responsible for the maintenance of the physical plant in a state of repair and for decisions on board policies relative to such vital matters as heat, light, power and general upkeep. Regular inspection of the hospital plant should not be a duty of the property committee, nor should it be required to make decisions on matters relating to minor repairs or to routine upkeep.

Handling Publicity

The scope of the work of the social service committee may be wide or narrow, depending upon the type of institution and the personnel of the committee. Matters relative to such things as the adoption of policies in regard to free care; cooperation with the committee on accounts; cooperation with local social service organizations and individuals interested in the social side of disease, should come before this group. Frequently the social service department requires the support and encouragement of this committee since so much misinformation is continually manifested relative to the activities and possibilities of good hospital social work. The superintendent of the hospital and the directress of social service should be ex officio members of this committee.

Publicity of an ethical and carefully considered nature is vitally necessary to the modern hospital. The committee on publicity must be informed as to what is being done by every other committee in the institution. It must develop close contact with the local press and matters of interest to the public should be sent to it from the superintendent's office. The annual report and all other reports for the perusal of the public should originate with this committee. A close contact must exist between the office of the superintendent and the chairman of this committee.

The board of trustees and its committees are of the utmost importance to the hospital and to its administrator. The superintendent is the representative of the board and the board is, in the last analysis, responsible for all of his acts. A board can render the greatest service to the patient by requiring prompt and efficient execution of its policies by the superintendent and by refraining from interference in the actual administration of the hospital. The board and the superintendent each have definite duties toward the sick and neither can satisfactorily perform the work of the other.

Maintenance, Operation and Equipment

Conducted by JOHN C. DINSMORE and DR. R. C. BUEK

Proper Insulation Reduces Fuel Costs

By WILLIAM B. SELTZER

Superintendent, Bronx Hospital, New York City

BRONX Hospital, New York City, recently completed the installation of an underground steam line which, by eliminating an old boiler plant, and centralizing all the heating service of the hospital, has been able to effect unusually large economies.

The hospital which originally consisted of two small buildings on the west side of the street was supplied with steam from a heating plant located between the buildings. A few years ago a large modern hospital building was constructed on the east side of the street, directly opposite the old building. The old buildings were retained as a dispensary and the old hospital building itself was remodeled into a nurses' home. The new building was equipped with a modern heating and power plant but the old buildings were served rather inadequately by the worn-out equipment in the original boiler plant.

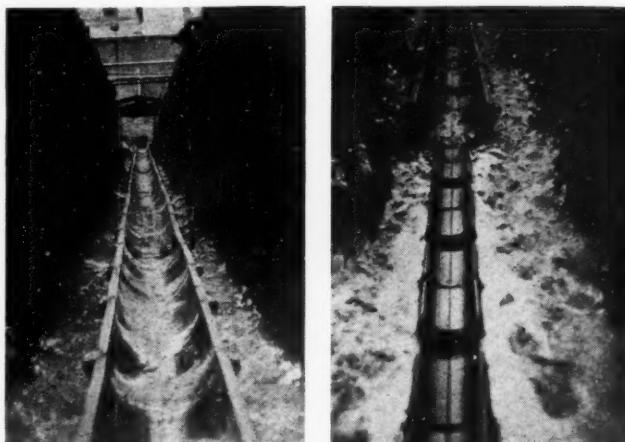
Old Boilers Discarded

It was the intention ultimately to connect the old buildings to the modern heating plant and as time went on it became increasingly evident that the old boilers should be discarded. Accordingly our chief engineer made the necessary plan for merging the two heating plants into one. We carefully considered the type of construction that we should install in order to have these underground pipes properly insulated so that there would be as little loss as possible in transmitting the steam. Simplicity of installation and low heat loss were important factors, as we intended having the work done by our own maintenance department.

The distance from the main building to the old boiler room was 210 feet but a part of this run was across a busy thoroughfare where it was decided to use cast iron conduit with vitrified tile conduit for the balance. It was considered advisable to install a 5-inch low pressure line for winter heating and hot water requirements, a 2-inch low pressure line for summer needs and also a 2-inch return line.

Provision was made to use the 2-inch steam line also in the winter time if necessary by providing boiler pressure of 90 pounds and reducing to 10 pounds at the old boiler room. This was merely intended as an emergency hook-up.

A 15-inch conduit was used to house these three pipes which were supported in the conduit by means of cast iron pipe supports designed so that



An insulated underground steam line centralizes the hospital's heating service and has proved economical.

the load of the pipe was not on the conduit but carried externally to the heavy base drain cradle. Steel piping was used for the steam lines and brass for the return line. Screwed couplings were used in all pipe with the additional precaution of welding the ends of the couplings. Before the installation was applied, pipes were tested hydrostatically. The insulation used was a long fiber asbestos, especially processed so that it will not absorb moisture. This feature is considered important on underground work in order to save heat and prevent the pipes from corroding. It is essential that the pipes remain dry. The insulation was packed firmly around the pipes.

Slip type expansion joints were used on the steam and return lines installed at each end of the

line with an anchor located midway, embedded in a concrete block. Traps were provided to remove the condensation at the old boiler room which was at the old end of the line. A vacuum pump was installed to take care of the returns from the heating system.

The accompanying table shows the amount of savings. The costs of coal and oil used in this analysis are those of February, 1934.

The cost of installing the work was as follows:

Conduit system	\$1,200
Outside — piping, excavation labor, etc... 1,500	
<hr/>	

Cost of outside work.....	\$2,700
Piping and work inside building.....	800
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Total cost \$3,500

The amount of yearly savings effected by eliminating the old boiler plant amounts to \$4,904.38. Based on a capital investment of \$3,500 it will readily be seen that this represents a yearly dividend of 140 per cent.

Another important consideration is the fact that the hazard and unreliability of the old plant is eliminated, which ensures a considerably better heating service.

The efficiency of the installation is clearly dem-

ECONOMIES EFFECTED BY ELIMINATING OLD BOILER PLANT

Cost to Operate Old Boiler Plant

Winter Operation Average:

3 tons coal @ \$6.50 =	\$19.50
Firemen (2)	6.60
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Cost per day.....\$26.10

Heating season 210 days @	
\$26.10 =	\$5,481.00

Summer Operation Average:

½ ton coal @ \$6.50	\$3.25
Fireman (1)	3.30
<hr/>	

Cost per day.....\$6.55

Summer season 155 days @	
\$6.55 =	1,015.25
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Cost per year.....\$6,496.25

Cost of Steam Supplied From Main Building

Readings From Boiler House Power Gauges:

Boiler No. 1	Boiler No. 2
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Steam on to outside line	210 B. H. P.	215 B. H. P.
Steam off to outside line	175 B. H. P.	200 B. H. P.
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Steam supplied to outside line 35 B.H.P. 15 B. H. P.
Equivalent evaporation 50 B. H. P. \times 34 = 1700 lbs.
steam per hr.

Boiler evaporation 14 lbs. steam per lb. oil fuel
1700

14 = 121.4 lbs. oil or 15 gals. per hr.

Operating period 18 hrs. \times 15 = 270 gal. per day.

Cost of oil 2½ cents per gal.

Cost of Winter Season 270 \times

2½ \times 210 days = \$1,417.50

Cost of Summer Season 45 \times

2½ \times 155 days = 174.37 \$1,591.87

Yearly Saving \$4,904.38

CONDENSATION TEST DETERMINES THERMAL EFFICIENCY

2" H.P. Steam line 210 lineal feet. Outside temperature 20° F.

90 lbs. initial pressure, 75 lbs. delivered pressure.
Condensation from trap 16 lbs. in 5 hrs.

Condensation per hr. — 3.2 lbs.

Latent heat at 75 lbs. pressure = 894 B.t.u. per lb.

Condensation from insulated line = 2861 B.t.u. per hr.

Estimated condensation developed into

steam account pressure drop

Total heat at 90 lbs. pressure	1187.5 B.t.u. per lb.
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Total heat at 75 lbs. pressure	1184.6 B.t.u. per lb.
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2.9 B.t.u. per lb.

Flow: 1700 lbs. per hr.

Condensation reevaporated $1700 \times 2.9 = 4930$ B.t.u. per hr.

Total heat loss 2861 plus 4930 = 7791 B.t.u. per hr.

Estimated heat loss from uninsulated pipe
under same temperature conditions.

131 sq. ft. surface \times 305 temp. diff. \times 3.3 B.t.u. loss per
sq. ft. = 132,000 B.t.u. per hr.

Efficiency = $\frac{132,000 - 7791 \times 100\%}{132,000} = 94.3\%$

onstrated by the following analysis of an actual test on the condensation in the underground line, which shows that the insulation saves 94.3 per cent of the heat loss from the same pipe uninsulated.

We feel that considerable savings can be made in hospitals by properly checking up on all steam lines whether high pressure or low pressure, and hot water lines and return lines, to see that they are properly insulated, since considerable money can be saved with proper insulation. This is especially true with fuel costs at present prices.

Gas Range Equipment

In September, 1933, the State of Wisconsin General Hospital, Madison, replaced its old style heavy duty ranges with six closed hot top and four open top new style heavy duty ranges, embodying improved heat controlled, insulated ovens and improved top surface burners. Although the former ranges were only ten years old, this replacement resulted in a 27 per cent reduction in gas consumption in approximately fifteen months.

Costs Ratio of Paint and Painters' Labor

A recent study of the annual cost of painting a large hospital unit developed the following interesting data:

Annual cost of paint pigment.....	\$ 787.50
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Annual cost of vehicle (oil and turpentine).....	274.70
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Annual cost of miscellaneous supplies.....	396.46
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Total annual material cost.....	\$1,458.66
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Annual labor cost.....	\$3,540.00
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These ratios are for painting when the air spray gun was used whenever possible. Since the spray used about 25 per cent less paint than is used for hand work, these relationships would change were the painting done by hand.

MAINTENANCE, OPERATION AND EQUIPMENT

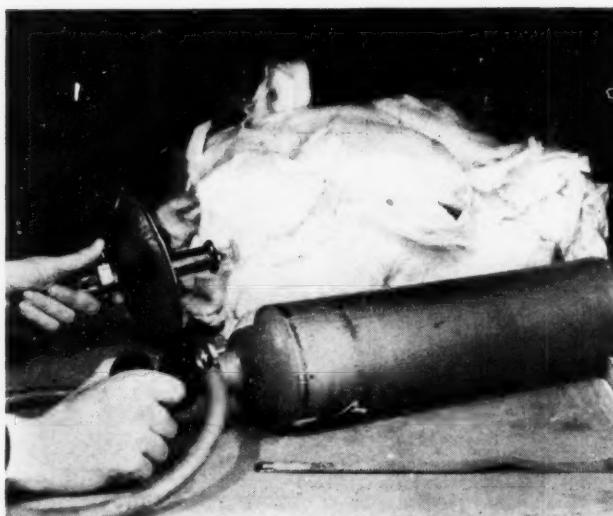
Loosening Syringes

By VERNE A. PANGBORN

Director of Hospitals Stores, University of Iowa Hospital,
Iowa City, Iowa

Syringes that stick are the cause of much annoyance to floor nurses and supervisors, not to mention the usually costly result in time and material loss of trying to loosen them by the regular methods. A novel but effective and economical method of loosening syringes no matter how tightly stuck they may be has been devised at the University of Iowa Hospitals.

The apparatus consists of a "D" tank of carbon dioxide to which is attached a five-foot length of high pressure hose.



Plenty of soft material should be used to catch the piston as it shoots loose or it will shatter.

At the other end of this hose are securely clamped a round hypodermic needle hub, and a saucer shaped tin shield. In the corner of the shelf on which this apparatus stands we have piled a considerable amount of cotton waste from the surgical dressing room. The tip of the syringe is fitted into the metal hub, the hose is held firmly immediately back of the tin shield and the syringe is pointed into the mass of cotton. The gas is slowly turned on and usually the piston pops out almost immediately, although sometimes considerable pressure and time must be used. The waste catches the piston and, presto, there you have your two syringe parts all ready to be cleaned and put back into use.

In order to get the cooperation of the nursing staff we exchange a good syringe for the stuck one returned to us and then loosen it at our convenience. This exchange is made without requisition, and this lack of red tape makes it fairly easy to get the necessary cooperation.

There are several things to remember in using this method if it is to prove satisfactory. The first is to use plenty of soft material to catch the piston as it shoots loose or it will shatter. The second is to hold the hose firmly next to the shield so that the syringe will not jump when the piston comes loose or the tip on the barrel will be broken. The third is to be sure to use a large enough shield to protect the operator in case a weakened syringe breaks under pressure. We have had this happen three times and you may

rest assured that we fashioned our shield after the first incident.

Do not be surprised if it takes considerable pressure and a little time to loosen the smaller size syringes for they are the ones that cause the most difficulty. If much pressure is used you may find the syringe tip frozen to the hub in which case you must wait until the frost has disappeared before attempting to loosen the barrel from the hose. The larger sizes loosen easily.

The total cost of such an outlay is only a couple of dollars and the operating expense approximates one cent per syringe provided no gas is wasted. We have found that carbon dioxide gas is the best to use, just why I am not sure, but the syringes do seem to come apart more easily when this particular gas is used.

This apparatus is not a plaything and should be treated with due respect and caution. Given careful handling, it is a satisfactory means of meeting a distressing problem. While the idea is not original, I believe our particular set-up is unique in its simplicity and effectiveness.

One Way to Get Bills Paid

By WILSON L. BENFER

Auditor, Toledo Hospital, Toledo, Ohio

One of the most important factors in successful collection of hospital accounts is a definite understanding with the patient or the person responsible for payment of the account at the time of admission. The rate of the room and the charges for various extra services should be explained, and if the patient knows approximately the length of his hospital stay, it is a good plan to estimate the amount of the bill. At this time the admitting clerk or other person designated to do this work has an opportunity to explain to the patient the rule of the hospital regarding payment of accounts.

At Toledo Hospital the admitting clerk explains the rates to the patient and at the same time informs him regarding the rule which calls for payment weekly in advance. If a patient is unable to pay in advance at the time of admission he is ushered to the credit department where arrangements for deferred payments are made. If it is necessary for a patient to extend his payments over a prolonged period of time, we have a system of financing our accounts through a local finance company. In this way the hospital receives payment of the account in full within a few days following the patient's discharge, and the patient has twelve months in which to pay his obligation to the finance company. The debtor is not asked to give any collateral. All that is required is his signature on a note, and then this note is endorsed by the hospital.

Naturally, under such a plan the interest rate is somewhat higher than bank interest, but far from the usual finance company plan and not high enough to create an undue additional burden for the patient. This system cannot be used in the case of all unpaid accounts. The finance company will not take accounts under \$50. The accounts that fall in this group must be handled by the hospital. It is the policy of this institution to have notes signed for these accounts.

A close follow-up system on unpaid accounts will minimize the loss to the hospital. The debtor should be notified

MAINTENANCE, OPERATION AND EQUIPMENT

a few days prior to the time that his payment is due. If payment is not received on the due date or a day or two after that time, another letter should be written again calling his attention to his account. Promptness on the part of the hospital in following up the account will impress upon the debtor that it is imperative that he should meet his obligation with reasonable promptness.

All accounts cannot be handled in the same manner, however. No doubt every hospital has certain accounts for which a bill is not rendered until the patient is discharged from the hospital. It would be fine for all hospitals if there were more accounts like this.

At Toledo Hospital it is a policy not to discuss financial matters with the patient provided there is some other member of the family with whom financial arrangements can be made. May I again stress the importance of having financial arrangements made at the time of admission of the patient, or if this is impossible, soon after that time. An account should never be allowed to accumulate for two or three weeks without some definite understanding regarding payment.

A Simple Automatic Filter

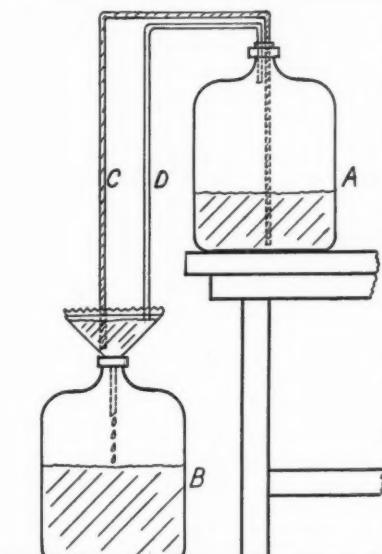
Some solutions made in hospital pharmacies cannot be readily filtered in a simple mechanical disc filter due to the oil present. These solutions must be filtered through talc. There are on the market disc filters designed to use talc, but the equipment is complex and expensive. Where such solutions are made in large quantities and in large containers there is ever present the difficulty of pouring the liquid

from the container to the funnel holding the filter paper and talc. Another difficulty encountered is that of keeping the funnels filled.

In order to solve these difficulties a simple automatic filter has been devised at the University of Chicago Clinics. As far as is known this type is not in use elsewhere.

In constructing this filter an old principle was used, namely, when a liquid is poured from a container, the volume of the liquid poured must be displaced by an equal volume of air or the pouring stops.

The accompanying illustration shows the filter. "A" is the five-gallon bottle containing the solution to be filtered. "B" is the five-gallon bottle which will receive the solution. The two bottles are connected by two pieces of hollow glass tubing. "C" extends from the bottom of "A" to a point part way down in the funnel. "D" extends from just inside the cork of "A" to the highest point in the funnel which it is desired the solution shall reach. Once the flow is started



from "A" to "B" it continues automatically, the level of the solution never exceeding that point already predetermined by rod "D." "D" regulates the flow of air into "A." When the level of solutions in the funnel covers the opening of "D" in the funnel the flow of the solution through "C" is stopped. As the level of the solution in the funnel falls below the opening of "D," air again enters "A" and the flow through "C" is continued. This action continues as long as there is solution to be filtered and the connections in "A" remain airtight.

The advantages of this equipment are: (1) time saving resulting from automatic equipment; (2) less waste due to prevention of spilling; (3) increase in the amount of solution that can be filtered, since a battery of filters can be kept going without supervision.

How to Mark Glass

Marking of glassware, especially heat resistant glassware, has been difficult to accomplish safely. A new etching ink is now available and has been found useful by the University of Pittsburgh Medical Center and other institutions for the following purposes.

1. Hospital drinking glasses may be easily marked to indicate the service to which they belong, that is, by use of the rubber stamp and the new etching ink, glasses are so marked as to keep cafeteria glasses and patients' glasses separate.

2. Clinical fever thermometers cannot be marked with the name of the purchaser, according to the NRA code. Letters as small as 3 millimeters high can be easily etched by the use of a rubber stamp.

3. The indelible marking of flasks for solutions, especially intravenous solutions, has always been difficult. This new preparation will mark heat resistant glassware. It thus offers increased safety by providing proper identification.

4. By use of a special low priced circular rubber stamp, the name of the hospital may be etched on electric light bulbs to reduce theft.

5. The Falk Clinic, Pittsburgh, is going to etch its name on all syringes to reduce theft, since the high cost of syringes is a matter of concern.

6. When it is desirable to run tests of service on several lines or brands at the same time, an ordinary pen can be used to code and date the items.

7. For prescription bottles a 50-cent rubber stamp will mark the name of the clinic and even the whole upper portion of the usual label. This etched portion is permanent and may serve as desirable advertising and prevent the re-use of bottles by others. When many bottles of the same preparation are issued, the name of the product or its code can be stamped on the bottle (at less cost than a label) to prevent confusion should the label become illegible or should it be detached.

8. By dipping microscope slides and other laboratory glassware into the solution, a frosted surface is produced which easily takes ink or pencil writing. This technique is much superior to glass writing or wax pencil.

Many other uses for identification, protection and testing may be found. There are other products for the same purpose but this report covers only the one preparation described here.

Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Lending Variety and Color to the Restricted Diet

By MARY HARMAN RISTE

Dietitian, Butterworth Hospital, Grand Rapids, Mich., and

LILLIAN B. STORMS

Fremont, Mich.

BLAND diets sometimes need to be continued over a long period of time, and as they must necessarily consist of foods that are not mechanically or chemically stimulating, they soon become monotonous.

Patients required to remain on bland or soft diets, as a direct result of this monotony in palatability and texture tend either to restrict their food intake below the amounts desirable or fail to adhere to the prescriptions. The effectiveness of the treatment is minimized and recovery retarded when the dietary regimen is not followed, and we are offering some suggestions that will assist in giving variety to bland diets and thus aid in making the recommendations of the physician more acceptable and more effective. The general esthetic as well as therapeutic value of a limited diet is of importance.

The recommendations for bland or low residue diets frequently eliminate or greatly restrict the use of vegetables because of fiber content. Strained fruits and vegetables, particularly the commercially prepared, which are finely strained, have had most of the crude fiber eliminated. This makes it possible to include these foods in many such diets. They supply minerals and vitamins, both of which may be below the minimum requirements in restricted diets, they add variety in flavor and, equally important, they lend color and attractiveness to the service.

For a bland diet both variety in foods and color are needed. The presence of color, pleasing color combinations and the use of attractive dishes all help in maintaining a restricted dietary regimen. The form or shape of food served also influences the esthetic appeal of the tray. Molds of various shapes are helpful, and strained vegetables in gelatin molds may be used to change the form as well as to add color.

The following menus and recipes may be used as a means of varying the monotony of restricted diets. Recipes for purées of different consistency may be adjusted to allow for more or less liquid.

MENU

Vienna Soup Imperial Sticks in Rings

Vegetable Ring Mold

Chopped Sweetbreads in Sauce

Jellied Peach Purée Banana Cream Sauce

Lady Fingers

Vienna Soup

2 quarts veal stock	2 egg yolks
1/4 cup barley	1 cup thin cream
1 carrot	1 cup asparagus purée
1 sprig parsley	Salt

Cook stock, barley, carrot and parsley. Add the yolks of two eggs diluted with one cup of thin cream and press mixture through a sieve, rubbing through as much as possible. Reheat and add one cup of asparagus purée.

Imperial Sticks in Rings

Cut stale bread in one-third-inch slices, remove crusts, brush with butter and cut slices in one-third-inch strips and rings. Put in pan and bake until delicately browned. Arrange three sticks in each ring.

Vegetable Timbale (Variegated) (Twelve Ring Molds)

3 tablespoons butter	1/4 cup broth
6 tablespoons flour	4 eggs
2 cups milk	1/2 cup each of thick purée of carrot, pea, beet and asparagus.

Make a sauce of the first four ingredients. Divide into four parts and when cool add a slightly beaten egg and a different purée to each part. Butter ring mold, place purées in mold, so that each fourth is a different color and

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flavor. Bake as timbale. This mixture must be stiffer than the standard timbale recipe, so that the raw mixtures will not run together. The purées should be strained so that as much liquid as possible is removed.

Banana Cream Sauce

Work one tablespoon of butter until creamy, add one tablespoon of flour and blend well. Then add gradually two tablespoons of sugar. Scald one-half cup of milk in a double boiler, combine mixtures and stir constantly until thickened. Then add the yolk of one egg and cook three minutes. Add one banana forced through a sieve and a pinch of salt. Chill and add one-half cup of heavy cream, beaten stiff.

MENU

Oyster Bisque	Melba Toast Rolls
French Cutlet	Béchamel Sauce (Light Seasonings)
Ritz Potatoes	
Jellied Blueberry Juice	Custard Sauce

Oyster Bisque

Heat one pint of oysters quickly in their own liquor, bringing them to the boiling point. Drain, reserve liquor and chop oysters. Press them through a sieve. Add milk to the oyster liquor to make three cups. Bind with two tablespoons each of butter and flour, add one cup cream, and for seasoning, salt and one teaspoon chopped parsley. Heat to boiling point, add the puréed oysters and one egg slightly beaten and serve immediately.

French Cutlet With Béchamel Sauce—(3 or 4 cutlets)

Combine $\frac{1}{2}$ cup boiled rice	Make forcemeat of
2 tablespoons tomato purée	$\frac{1}{2}$ cup raw breast of chicken
2 tablespoons water	4 tablespoons 30 per cent
1 egg yolk	cream
$\frac{1}{2}$ teaspoon salt	1 egg white
	Salt

Fill well buttered cutlet molds half full with forcemeat. Cover forcemeat with rice mixture and bake molds in a pan of hot water about twenty minutes. For the Béchamel sauce, follow standard recipe, omitting strong seasonings.

Ritz Potatoes

$\frac{1}{2}$ cup pea purée	3 cups mashed potatoes
2 tablespoons butter	Cream
Salt	

Season purée with salt and butter and add to hot mashed potato. If potato is dry, add cream to make it a consistency to tube. These potatoes may be tubed as a border to the cutlet mold or may be served on the side as a nest.

MENU

Cream of Beet Soup	Melba Croutons
Whitefish Soufflé	Stuffed Potato
String Bean Purée	
24-Hour-Old Bread and Butter	
Jellied Pink Diced Pears in Parfait	
Whipped Cream	

Cream of Beet Soup

$\frac{1}{2}$ cup beet purée	2 teaspoons melted butter
1 cup broth	1 cup top milk
	$\frac{1}{2}$ teaspoon salt

Combine ingredients. Bring to boiling point and serve.

Whitefish Soufflé

$\frac{1}{2}$ cup finely ground white-fish	1/3 cup milk
1/6 cup soft stale bread crumbs	1 egg white, beaten stiff
	Salt

Cook bread crumbs in milk five minutes, add whitefish and egg yolk, beaten until thick and lemon colored; then cut and fold in the white of egg. Turn into a buttered ramekin and bake in a moderate oven, in a pan of hot water, until firm.

MENU

Cream of Spinach Soup	Buttered Toasted Rusks
Chicken Force meat Cutlets	Tubed Pea Purée
Tomato-Potato Puff	
Jellied Royal Anne Cherries	
Frozen Whipped Cream Cubes	

Chicken Force meat Cutlets—(2 cutlets)

1 tablespoon butter	2 tablespoons stale white bread crumbs
$\frac{1}{2}$ cup milk	
1 egg white, slightly beaten	$\frac{1}{2}$ cup chicken force meat

Melt butter, add bread crumbs and milk and cook five minutes, stirring constantly. Add chicken and egg. Season with salt. Bake as a timbale.

Tomato-Potato Puff

1 1/2 cup soft mashed pota-toes	1 tablespoon butter, melted
1/3 cup strained tomatoes	$\frac{1}{4}$ teaspoon salt

Combine ingredients in order given. Put into buttered baking dish, bake in moderate oven (375° F.) for about 45 minutes.

MENU

Chicken Broth With Egg Balls	
Halibut and Spinach Mousse, Sauce	
Tubed Potato Nest with Carrot Purée	
Zwieback	
Prune Orange Fluff	

Egg Balls

1 hard cooked egg	1 teaspoon heavy cream
1 raw egg yolk	$\frac{1}{4}$ teaspoon finely chopped
$\frac{1}{6}$ teaspoon salt	parsley

Rub yolk of hard cooked egg through sieve, add white finely chopped and remaining ingredients. Add raw egg yolk to make mixture of right consistency to handle. Shape in small balls and poach in boiling water or stock.

If you are A DOCTOR ▽ A NURSE ▽ A DIETICIAN *read this brief story*

It was in 1918, that physicians became increasingly aware of the fact that even when calcium and phosphorus were supplied in the diet in sufficient quantities, still there was no assurance that these elements would be absorbed and properly utilized unless adequate amounts of Vitamin D were supplied. The deficiency of Vitamin D, as you know, causes widespread physical disturbances, especially rickets in infants and growing children; and the withdrawal of lime salts from the teeth and bones during pregnancy and lactation. These facts focused attention on the necessity of discovering some method whereby the essential sunshine vitamin might be made readily available. And then came . . .

Dr. Steenbock's Research

At the University of Wisconsin, Dr. Steenbock struggled with this baffling problem, as did Dr. Alfred F. Hess of New York, and others. At last Steenbock, and shortly thereafter Hess, made a startling discovery—Vitamin D could be introduced into certain foods and pharmaceuticals by irradiation with ultra-violet light. The efficacy of irradiated products in the prevention and cure of ailments due to Vitamin D deficiency has been abundantly proved—by research on both animals and humans. Dr. Steenbock took out a patent to provide against any danger of the indiscriminate use and exploitation of his discovery by the unethical.

How This Process Was Put To Work

The Wisconsin Alumni Research Foundation was incorporated by a group of University of Wisconsin alumni. To this foundation, Dr. Steenbock assigned his patents. It grants licenses to representative manufacturers for the use of inventions developed and assigned to it. No license is granted under this patent except for producing such products as can contribute definite benefits to the public.

How License Fees Are Used

A substantial portion of the net returns is devoted to clinical studies on products irradiated with Vitamin D. Large sums are spent on laboratory control to insure that correct Vitamin D potency is maintained. Other sums are devoted to new scientific research projects.

Potency Control

Each licensee submits samples of his product to the Foundation's control laboratories at regular intervals for biochemical assay to check the anti-rachitic potency. But that's not all! Over the counters of hundreds of food and drug stores, purchases of all activated products are made by Foundation representatives, to see that these products *as sold to the users* are equal in potency to the standard set by the Foundation. Expensive? Yes, but essential to the protection of the public.

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Prune Orange Fluff

1 package orange gelatin 1 can strained prunes
1 tablespoon of confectioner's sugar

Dissolve gelatin in one pint of boiling water. Chill. When slightly thickened, beat until consistency of whipped cream, add strained prunes and sugar and whip until thoroughly blended. This makes six generous portions. Whipped cream makes it a de luxe dessert, but it is good served plain.

MENU

Swedish Fish Soup
Poached Egg on Rusk
Spinach and Liver Soufflé
Rice Cream With Maraschino Juice

Swedish Fish Soup

1 quart fish stock (haddock)	1 cup top milk
2 tablespoons butter	½ cup carrot purée
2 tablespoons flour	½ cup pea purée
1 tablespoon finely chopped parsley	

Season fish stock lightly with salt. Strain. Bind with butter and flour. Add milk and vegetable purées. Just before serving add parsley.

Spinach and Liver Soufflé—(2 servings)

1 teaspoon butter	2 tablespoons spinach purée
1 teaspoon flour	2 tablespoons liver purée
¼ cup milk	1 egg white, well beaten
Pinch salt	

Make a white sauce of butter, flour and milk. Remove from fire and add salt. Add spinach, liver and well beaten egg white. Pour into well greased custard cups. Place cups in a pan of hot water, and bake in a moderate oven until set.

Rice Cream

1/3 cup cold boiled rice	½ teaspoon powdered sugar
1/3 cup stiffly whipped cream	1 tablespoon maraschino juice

Add sugar to whipped cream. Fold into rice. Place in glass sherbet and serve with maraschino juice.

MENU

Cream of Chicken Soup
Spinach Timbale on Toast Round Thin Cream Sauce
Rose Nectar
Pink "Cinnamon" Apple
Unsalted Cracker Spread With Pink Cream Cheese

Vegetable Timbale

1 egg, well beaten	½ cup vegetable purée
½ tablespoon butter	¼ cup white sauce
1/3 teaspoon salt	2 tablespoons chicken stock

Turn into buttered molds. Set in pan of hot water, cover with buttered paper and bake till firm at 325° F.

White Sauce

2 level tablespoons butter	1 cup milk
2 tablespoons flour	Salt

Turn into buttered molds. Set in pan of hot water, cover with buttered paper and bake till firm at 325° F.

Pink "Cinnamon" Apples

4 apples	¾ cup water
½ cup sugar	Red vegetable coloring as needed

Core and pare apples. Cook sugar and water five minutes. Add coloring. Then add apples to syrup and cook slowly until tender and transparent. Baste the apples often and turn them occasionally.

MENU

Asparagus Broth With Quenelles
Carrot Timbale With Pea Sauce Toast
Saratoga Potatoes
Frozen Pistachio Junket
Peach Purée Sauce

Quenelles

Shape chicken or veal forcemeat mixture into small balls. Poach in boiling salted water or stock.

Saratoga Potatoes

Boil potatoes in their jackets, drain and let stand overnight. Peel and cut in small cubes. Place in top of double boiler, cover with cream and season lightly with salt. Cook in double boiler.

Frozen Pistachio Junket With Peach Purée Sauce

Into the freezer can put 2 cups lukewarm milk, 2 cups 30 per cent cream, ¾ cup sugar, one tablespoon vanilla, 1 teaspoon almond extract, and enough color paste to make a delicate green. Add 2 curdled milk tablets dissolved in cold water and let set. Freeze and serve in glasses with peach purée sauce.

Peach Purée Sauce

Drain the syrup from a can of peaches. Measure one cup of syrup and heat. Thicken with 1 teaspoon arrowroot made smooth with 2 teaspoons cold water. Boil five or six minutes, then cool. Add ½ cup peach purée. Better results will be obtained if peaches with a medium degree of syrup are used.

MENU

Purée of Mushroom and Pea Soup
Jellied Tomato Purée Ring With Cottage Cheese
Toasted Bread and Butter Sandwich
Clubbed Potato
Green Colored Apple Snow

Jellied Tomato Ring With Cream Cheese Center

½ cup strained tomatoes	½ cup lightly seasoned chicken broth
½ cup water	
½ teaspoon gelatin	Salt

Soak the gelatin in water. Heat stock with salt and tomato. Add to the soaked gelatin. Strain. Turn into a ring mold. Unmold when set and fill center with cottage cheese. The attractiveness of the dish will be enhanced if watercress is used as a garnish.

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	% Protein	% Fat	% Carbo-hydrates	% Ash	% Calcium	% Phos-phorus	% Iron	Calories per lb.	Vitamin B, Sherman Units per lb.
Ralston	14.5	2.20	72.0	1.6	.04	.37	.006	1800	900
Wheat flakes	13.0	1.4	74.0	2.2	.05	.37	.005	1500	Destroyed by toasting
Farina	11.0	1.4	76.0	0.4	.02	.13	.0008	1600	Too little to measure
Corn flakes	8.0	.4	87.0	3.0	.02	.12	.0009	1700	Destroyed by toasting
Rolled oats	16.0	6.0	68.0	1.9	.06	.42	.004	1800	200
Rice, white	8.0	0.3	79.0	0.4	.01	.10	.0009	1600	None

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How to Meet the Diet Problem in a

By LEOTA WEST
Dietitian, Ravenswood Hospital, Chicago

THE dietary department at Ravenswood Hospital, Chicago, functions smoothly and efficiently in a relatively small amount of space considering the number of persons served daily and the intensity of the special diet demand. All employees, guests, doctors and patients are served from the same kitchen, except patients receiving special diets.

The entire department is under the supervision of one dietitian, who is assisted by another dietitian and two senior student nurses, in addition to her regular staff of chef and twenty helpers.

The department occupies the entire basement area of the west wing of the hospital. With more careful planning it could have been housed in much less space and to more practical advantage. The department consists of: dietitian's office, 9 by 8 feet; main kitchen, 50 by 12 feet; special diet kitchen, 15 by 12 feet; pastry room, 15 by 12 feet; dishwashing room, 10 by 12 feet; guests' dining room, 10 by 12 feet; doctors' dining room, 15 by 12 feet; nurses' dining room, 50 by 12 feet; employees' dining room, 15 by 12 feet; storeroom, 14 by 12 feet; winter vegetable cellar, 4 by 6 feet.

Before we consider the mode of service let me give a general idea of the main equipment and dining space accommodation that enters into the successful serving of an average of 625 tasty meals a day.

The main kitchen is equipped with three large ice boxes having brine refrigeration from the house plant. One is used exclusively for meat and poultry, one exclusively for vegetables, and one exclusively for dairy products. The equipment is as follows:

- 2 large preparation tables with shelves
- 3 sinks
- 1 large meat block
- 1 large steamer having three compartments, where all vegetables are steamed
- 2 steam cookers (soup vats) one 40-gallon capacity and one 20-gallon capacity, used in the cooking of soups, hams or cereals
- 1 potato peeler, used for other vegetables also
- 1 16-inch food chopper
- 1 stationary can opener
- 1 large two-oven gas range for roasts and vegetables
- 1 gas soapstone heater
- 1 grill with broiler
- 1 mixer or beater
- 1 8-foot steam table
- 1 10-foot table for salads

150-Bed Hospital

- 1 8-tier rack for desserts
- 1 ice cream refrigerator, run from house plant
- 1 bread slicing machine
- 1 cabinet for supplies
- 1 6-gallon coffee urn

The special diet kitchen is equipped with:

- 4 porcelain top preparation tables
- 1 supply table
- 1 six-burner gas stove with oven and grill
- 1 large supply and dish cabinet
- 1 medium sized ice box
- 1 dumb-waiter
- 1 double electric toaster
- 1 electric drink mixer
- 1 electric orange squeezer
- 2 gram scales

The pastry room is equipped with:

- 1 large preparation table with shelf and drawer space
- 1 small preparation table
- 1 large baking stove with three ovens
- 1 cabinet and shelf for supplies

The dishwashing room is equipped with large deep sinks having deep wide trays. All glasses and silverware were washed by hand until we learned of a very satisfactory dishwashing powder that retained their luster.

The guests' dining room accommodates twelve persons, and has a buffet and four tables. The doctors' dining room has six tables and twenty chairs, a buffet, an electric plate, and one service table. The nurses' dining room has eight tables that seat seventy-two persons, one buffet, one service table, one electric plate, and one 6-gallon coffee urn. The employees' dining room has two large tables and one buffet and accommodates twenty persons.

The head dietitian makes out the menu for the entire establishment the day before and copies are made and sent to all nursing departments. The head nurse on each floor makes out her dietary requisition for the day and turns it in to the dietitian's office by 8 a.m. The head dietitian then makes the schedule for the kitchen showing the chef and her helpers the exact number of general diets, light diets, soft diets and liquid diets required by each floor.

Shortly before the time for the dining rooms to open the five food carts are made up. All food is served on plates from the main kitchen. The required number of full diets are placed in racks which fit in the heated food carts and are ready to

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transfer to the patients' trays. These food carts are heated by soapstones but we are installing an electric food conveyor at a cost of \$2,000 to improve our food service still further. The soup is taken to the floor in 5-gallon vacuum soup kettles. The lower part of each cart has a compartment for salads and any special orders on the regular house diets.

No food is kept in the diet kitchens on the floors. Everything, including the exact number of slices of bread and pats of butter is calculated and sent in required amounts to the floors. This eliminates waste and errors.

After the food carts have gone to the floors the food for the dining room service is transferred to the eight-foot steam table. This table has three meat pans with copper tops, three gravy jars, four vegetable jars, one soup jar and a large compartment for warming the dishes. From here the interns, nurses and employees are served in cafeteria style, the staff doctors and guests being the only persons who are served by waitresses at the table.

All salads and pastries, desserts and muffins are made in the pastry room. This leaves the main kitchen free for roasts, vegetables and service.

The head dietitian makes out all special diets which are taken care of by senior student nurses who have had their course in dietetics and diet in disease prior to their training in the diet kitchen, these courses having been given by the dietitians of the hospital. Special trays are prepared in the special diet kitchen, served there and sent direct to the patients' rooms. This minimizes the chance of error that might occur if the trays were served on the floors—it also assures the patient of a fresh hot meal.

The milk laboratory, on the third floor near the nursery, is also under the dietary department. Here all baby formulas are made up daily by senior student nurses, with strictly sterile technique.

Coffee is made fresh in glass coffee brewers in the diet kitchen on each floor. This has a psychologic value for the smell of coffee being brewed wafts down the halls and greatly increases the appetites of patients. When they get their trays the entire meal is up to their expectations and is not spoiled by poor coffee, as is so often the case when other modes of making coffee are used.

All vegetables are steamed, baked, grilled or boiled—nothing is fried for patients. Broths are cooked in soup vats and allowed to stand for one whole day after which they are skimmed—assuring the patient of fat-free broths. We serve whole wheat, rye, white and raisin breads. The ice cream is served in paper cups, approximating forty cups to one gallon of cream.

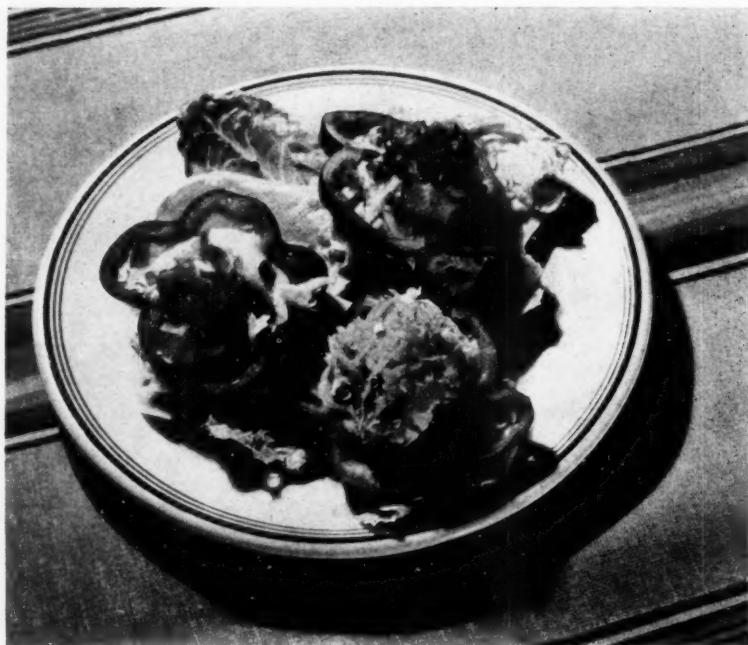
Patients receive four ounces of freshly squeezed pure orange juice every other morning. One case of size 2/16 oranges is consumed daily. No cold storage eggs are used in this hospital. Only fresh eggs, pure butter, and whole milk are used in cooking and for table service.

A storeroom is located across from the main kitchen and here we always keep one day's supply of foodstuffs in advance.

The majority of canned goods are bought by contract on yearly bids. Our staples are bought weekly on bids from four or five houses. Fresh fruits, vegetables and meats are bought three times weekly.

No. 10—Tremont Salad

By Arnold Shircliffe*



Coleslaw
Grated Carrot

Chopped Tomatoes
Minced Green Pepper

ON A BASE of lettuce, place three piles or "mountains" of coleslaw, made with sour cream dressing. Sprinkle the top of the first pile with grated highly colored carrot, the second with chopped skin and pulp of a red ripe tomato, and the third with finely minced green pepper. Cut three thin slices from a green pepper and place a ring around each "mountain." Serve with creamy French dressing.

*Author of the Edgewater Beach Salad Book.

1. Are prunes "acid"?
2. Do prunes help in nutritional anemia?
3. Are the vitamins of prunes present after processing?
4. Is there a difference between sugar in prunes and ordinary sugars?
5. Is prune JUICE laxative as well as the whole fruit?
6. Is it the roughage of prunes that makes them laxative?
7. Are prunes a good source of mineral values?

NEW FOOD FACTS

revealed in these

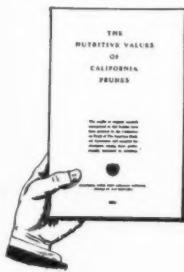
FREE BOOKLETS!



Due to the results obtained from a three-year program of scientific research, California Prunes have attained a new importance in the dietary. The nutritional information recently revealed (accepted by the Committee on Foods of the American Medical Association) already has proved of great importance to doctors,

nurses and other professionally-interested groups. The results of this three-year research program are summarized in the free bulletins described below. Merely check the material desired, and it will be forwarded to you free, on receipt of the attached coupon.

NUTRITIVE VALUES TOLD



1. A complete digest of the scientific research and experiments, telling of the two laxative agents, the effect of prunes on the alkali reserve, the vitamin and mineral content and the energy value of California Prunes.

UNUSUAL WAYS of SERVING PRUNES



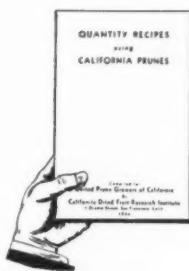
3. The most recent Prune Recipe Book, entitled "Prunes Add Variety," describes twenty-nine new and attractive prune dishes, ten beautifully illustrated. These recipes make it possible to serve this delicious and economical fruit in many varied and appealing new ways.

PRUNES IN THE DIET



2. A new Prune Diet Manual, giving information on new and wider uses of prunes in the diet based on the recently discovered nutritional values of prunes. Of special interest to hospital dieticians.

PRUNE RECIPES for MULTIPLE SERVINGS



4. This booklet, "Prune Quantity Recipes," gives accurate directions for preparing prune recipes for multiple servings, economically planned. Of particular value to hospital stewards, and others having to do with the planning of meals.

UNITED PRUNE GROWERS OF CALIFORNIA, DEPT. 4-MH-5, 343 Sansome Street, San Francisco, California
Please send me, free, the material listed below which I have checked:

- Bulletin on The Nutritive Values of California Prunes.
 New California Prune Diet Manual.

- Booklet describing New Ways to Serve California Prunes.
 California Prune Recipes for Multiple Servings.

Name.....

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State.....

I am connected with the following institution:.....

May Breakfast and Supper Menus*

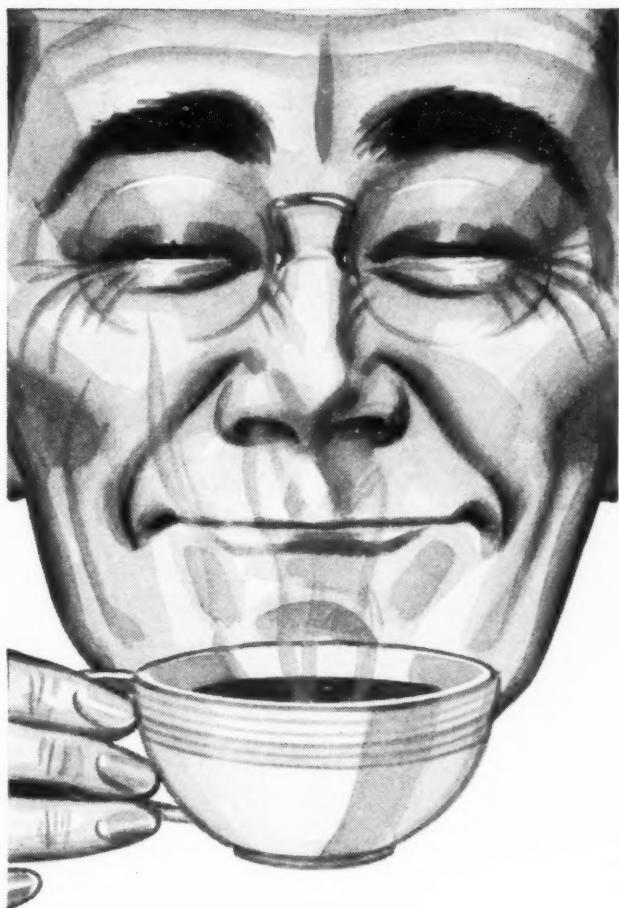
By LENNA F. COOPER¹

Chief, Department of Nutrition, Montefiore Hospital, New York City

BREAKFAST		SUPPER					
Day	Fruit	Eggs	Soup or Cocktail	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Grapes	Scrambled	Cold Schave	Farmer Cheese Salad	Boiled Potatoes	Radishes	Lacqua Roll
2.	Orange	French Toast	Potato Soup	Scrambled Eggs	Tomato Ketchup	Fresh Spinach	German Apple Cake
3.	Stewed Figs	Omelet	Lentil Soup	Smoked Salmon	Potatoes in Jackets	Lettuce	Fruit Cup
4.	Grapefruit	Soft Cooked	Cream of Tomato Soup	Potato Kugel	Carrots	Scallions	Fresh Applesauce
5.	Baked Pear	Scrambled	Vegetable Soup	Baked Rice With Cheese and Mushrooms		String Beans	Lemon Soufflé Tarts
6.	Stewed Peaches	Omelet	Brown Farfel Soup	Deviled Eggs	Potato Salad	Sliced Tomatoes	Spanish Cream, Orange Sauce
7.	Fresh Pineapple	Scrambled	Savita Consommé	Cheese Blintzes	Baked Potatoes	Shredded Lettuce Salad	Stewed Prunes or Cherries
8.	Orange	Soft Cooked	Cream of Vegetable Soup	Baked Herring	Boiled Potatoes	Asparagus	Crumb Cake
9.	Stewed Mixed Fruit	Omelet	Pea Soup	Spaghetti With Cheese, Tomato Sauce		Kale	Ice Cream
10.	Bananas	Scrambled	Milk and Farina Soup	Chopped Egg Salad	Baked Potatoes	Black Olives	Cantaloupe
11.	Applesauce	Soft Cooked	Cream of Tomato Soup	Muenster Cheese Salad	Creamed Potatoes	Fresh Spinach	Raisin Cake
12.	Grapes	Scrambled	Cabbage Soup	Egg Barley With Mushrooms		Fresh String Beans	Floating Island
13.	Orange Juice	Omelet	Beet Borsht	Cottage Cheese	Boiled Potatoes	Radishes and Scallions	Apple Strudel
14.	Grapefruit	Soft Cooked	Milk and Corn Soup	Potato and Lentil Loaf		Stewed Tomatoes	Apricot Whip
15.	Fresh Strawberries	Omelet	Washington Chowder	Peppers, Stuffed With Rice and Cheese		Kale	Stewed Pear and Sand Tart
16.	Stewed Prunes and Cherries	Scrambled	Milk and Rice Soup	Baked Mackerel	Potatoes in Jackets	Lettuce Salad	Chocolate Tapioca Pudding
17.	Orange	Soft Cooked	Potato Oatmeal Soup	Swiss Cheese Salad	Beets	Cauliflower	Noodle Charlotte
18.	Bananas	Scrambled	Mongole Soup	Sturgeon Salad	Baked Potatoes	Coleslaw	Pecan Rolls
19.	Stewed Figs	Omelet	Cream of Asparagus Soup	Matzoth Brye		Fresh String Beans	Fresh Strawberry Sundae
20.	Grapefruit Juice	Soft Cooked	Vegetable Soup	Macaroni With Cheese		Shredded Lettuce Salad	Prune Whip
21.	Stewed Apricots	Omelet	Milk With Alphabet Soup	Potato Puff	Fresh Spinach, Sliced Lemon	Celery Hearts	Cheese Cake
22.	Fresh Pineapple	Soft Cooked	Corn Chowder	Sliced Eggs	Potato Salad	Black Olives	Prune Tart
23.	Grapes	Scrambled	Brown Barley Soup	Pickled Herring	Boiled Potatoes	Asparagus	Honey Cake
24.	Baked Pear	Omelet	Fish Chowder	American Cheese Salad	Baked Noodles With Bread Crumbs	Grilled Tomatoes	Applesauce
25.	Grapefruit Juice	Soft Cooked	Milk With Matzoth Farfel Soup	Tuna Fish Salad	Baked Potatoes	Radishes	Ambrosia
26.	Stewed Prunes and Apples	Scrambled	Vegetable Soup	Swiss Cheese Salad	Escalloped Corn	String Beans	Apricot-Oatmeal Cookies
27.	Orange	French Toast, Syrup	Potato Soup	Chopped Egg Salad	Carrots	Fresh Spinach	Peach Betty
28.	Stewed Apricots	Omelet	Brown Kasha Soup	Farmer Cheese and Sour Cream	Boiled Potatoes	Lettuce Salad	Fruit Cake
29.	Grapefruit	Soft Cooked	Spinach Borsht	Chopped Herring Salad	Baked Potatoes	Sliced Tomatoes	Boston Cream Pie
30.	Tomato Juice	Scrambled	Pea Soup	Baked Noodles With Cheese	Asparagus	Stuffed Olives	Fresh Pineapple
31.	Fresh Strawberries	Omelet	Milk and Corn Soup	Sardine Salad	Potatoes in Jackets	String Beans	Cup Cake, Butter Cream Frosting

*The author wishes to explain that the patients catered for are all charity cases and the menus are simpler than in hospitals with private and semiprivate patients. The supper represents the "dairy" meal of the day, as in Jewish hospitals meats and dairy products are not served together.

*Cereals, breads and beverages are omitted from the breakfast menus because of space limitations. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.



It SMELLS good!

ONE WAY to aid poor appetites is to prod them through the sense of smell. The full, rich aroma of good coffee is especially helpful in starting the flow of saliva . . . in luring the appetite to expectancy.

If patients exclaim how good the coffee is, you may be certain their appetites have been inspired. And the sure way to give them this coffee pleasure is to serve Continental always.

Continental Coffee is cup-tested four different times to be sure that every pound that leaves our ovens will taste good, smell good, look good.

Try a sample of our special hospital coffees now. Ask the Continental salesman who calls on you or write direct to Hospital Department 413 for a trial package.

CONTINENTAL COFFEE COMPANY
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Be sure to send for Continental's Card of Rules for making Good Coffee

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CONTINENTAL
AMERICA'S LEADING **SERVE** **FOUR TEST** **INSTITUTIONAL COFFEE**

3 important functions of **HORLICK'S**

The Original Malted Milk

**why hospitals everywhere endorse
it enthusiastically**

Adaptability to Convalescent Diet. Horlick's Malted Milk permits regulation of Caloric intake without upsetting delicate digestive systems. Always pleasing to the taste and a welcome addition to the diet, Horlick's can be mixed with either water or milk. Comes in either natural or chocolate flavor, in powder or tablet form.

As food in Treatment of Gastro-Intestinal Diseases. It is very easily digested, because in the Horlick process, the milk proteins are so modified by the action of enzymes that the finely divided particles form softer curds in the digestive tract. The mere addition of malted foods to cow's milk does not accomplish this.

As Carrier in X-Ray Diagnosis. Here Horlick's plays an important rôle by meeting all requirements for the perfect contrast meal. As carrier of barium sulphate it makes for a stable and uniform suspension, penetrating to every crevice of the gastro-intestinal tract. It is entirely neutral in action, palatable, non-irritating, and affords a smooth, homogeneous suspension at all times.

BE ON GUARD

There are many imitations of Horlick's Malted Milk. But do not be deceived. No imitation equals Horlick's for flavor or dependable high quality. Most are merely mechanical mixtures of raw cocoa, skim milk, inferior malt powder and ordinary sugar. Specify Horlick's the Original Malted Milk, and be sure,

Horlick's Malted Milk

FREE TO PHYSICIANS AND HOSPITALS

Send for new booklet "The Dietary Uses of a Valuable Food"

HORLICK'S MALTED MILK CORP. (MH-4-35)
Racine, Wisconsin

Please send your new booklet
"Dietary Uses of a Valuable Food"



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NEWS OF THE MONTH

Compulsory Health Insurance Endorsed by Two Professional Groups

Two professional organizations on opposite sides of the country endorsed the principle of compulsory health insurance on the same day last month. The house of delegates of the California Medical Association and the First District Dental Society of the State of New York are the organizations concerned. Both met on March 4.

The medical group, after a long and ardent discussion, adopted overwhelmingly a resolution recommending that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups. They proposed five principles, namely, (1) free choice of physician and hospital, (2) determination by the medical profession of scope, extent, standards, quality, compensation paid for and all other matters related to the medical and auxiliary services to be rendered, (3) exclusion of cash benefits, (4) adequate treatment for patients and adequate compensation for physicians, and (5) modification of above principles on recommendation of the profession.

The house of delegates also resolved

to offer immediately the full aid and cooperation of the California Medical Association to the committee of the California legislature now working on the problem of health insurance and to set up a special committee authorized and empowered to act for the association in matters pertaining to health insurance.

The First District Dental Society, which is the largest component society of the American Dental Association, resolved that dentistry, conscious of its social obligations as a progressive health service profession, must accept full responsibility for the development of the dental aspects of any sound system of health service that may be proposed. The society voted to approve in principle the current endeavors to provide adequate dental service for the low income groups of the population by a socially equitable method of distribution of the costs of such service and set up a committee of five to report to the society within three months a model dental section that may be incorporated in any health insurance bill that may be introduced in the New York State legislature.

on "Hospital Administration and Administrators." David Olmsted, manager, Hotel Savery, Des Moines, will compare hotel and hospital operation, and Grace B. Ferguson, director of the division of social administration of the University of Iowa will discuss "Social Service."

"Iowa Hospitals," by Clinton F. Smith, executive secretary of the University of Iowa Hospital, and "Hospital Library Service," by Elizabeth Lilly, hospital librarian, Free Public Library, Burlington, are two talks scheduled for Tuesday afternoon.

Hospital Gives Salary Increase to Employees

A 10 per cent increase in salary has been given the employees of Berwyn Hospital, Berwyn, Ill., a remodeling program completed, and all interest on indebtedness for the past year has been met and some principal paid off.

Under the direction of Oma M. Kull, superintendent, and J. F. McCarthy, business manager, many changes have been made in the hospital plant. The main operating room has been enlarged eight feet through the removal of a wall, and an oxygen tent and a gas machine, needed to replace an inefficient one then being used, were purchased. The gas machine has saved the hospital an average of \$75 a month since its installation.

In the kitchen an electric ice box has replaced an outmoded ice plant, a new ventilating fan draws off heat and fumes, and an electric mixer saves time and helps in the preparation of appetizing food.

The nurses' home is completely redecorated, has a new roof and new screens, several new pieces of furniture, and the grounds surrounding it have been reseeded and new hedges and shrubs planted.

The oil burners which had been heating the hospital for many years were taken out and an automatic stoker installed. The nurses' home, previously heated by a separate unit, was connected with the main heating plant, and this move with the new stoker has amounted to a saving of \$569.24. Most of the work connected with these renovations was done by the hospital engineer and his assistant.

Iowa Hospital Association to Meet in Iowa City

The program scheduled for the meeting of the Iowa Hospital Association, April 29 and 30 at Iowa City, will be presided over by T. P. Sharpnack, executive secretary of Broadlawns, Polk County Public Hospital, Des Moines; Robert E. Neff, administrator, University of Iowa Hospitals, Iowa City; Esther Squire, superintendent, Grinnell Community Hospital, Grinnell, and R. A. Nettleton, superintendent, Iowa Methodist Hospital, Des Moines.

Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison, Wis.; Dr. M. T. MacEachern, American College of Surgeons, Chicago, and Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., will lead the round table discussions.

Marietta Tanner, superintendent, Jane Lamb Memorial Hospital, Clinton, will talk on Monday morning on

the subject, "My Relationships with the County Board of Supervisors." This will be followed by a discussion of the future of denominational hospitals by the Rev. J. P. Van Horn, superintendent, St. Luke's Methodist Hospital, Cedar Rapids.

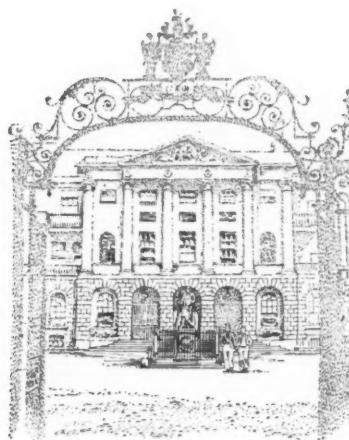
Visits to the commercial exhibits, Mercy Hospital and the University of Iowa Hospitals, where demonstrations of administrative and departmental activities will be made, are planned for Monday. Dr. Arthur C. Bachmeyer, director of clinics, University of Chicago, and past president of the American Hospital Association, will present the Matthew O. Foley Scholarship in the evening.

General principles of organization and management will be discussed by Prof. Karl E. Leib of the college of commerce, University of Iowa, on Tuesday morning. J. Dewey Lutes, director general of the American College of Hospital Administrators will talk

ELI LILLY AND COMPANY

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Guy's Hospital, London.

A member of the staff of Guy's Hospital wrote one of the early descriptions of pernicious anemia in 1849.

Modern research contributed a practical oral treatment of pernicious anemia in the form of Pulvules Extralin, Lilly. Each Pulvule of Extralin, Lilly, contains 0.5 Gm. of liver-stomach concentrate, and is equivalent in anti-anemic potency to approximately 20 Gm. of fresh whole liver.

The dose is tasteless—the potency assured.

Prompt Attention Given to Professional Inquiries

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

Special News Correspondents Chosen to Report for "The Modern Hospital"

To provide a more thorough news service, *The MODERN HOSPITAL* has enlisted the assistance of a group of state and provincial correspondents. Each of these persons has agreed to send to the magazine the news about events of general interest happening in his state or province.

Those who to date have accepted the invitation to act as correspondents are:

New England States: Maine, Dr. Joelle C. Hiebert, Central Maine General Hospital, Lewiston; Massachusetts, Dr. Charles F. Wilinski, Beth Israel Hospital, Boston; Rhode Island, Helen M. Blaisdell, Westerly Hospital, Westerly; Connecticut, Maud E. Traver, New Britain General Hospital, New Britain.

Middle Atlantic States: New York State (outside New York City), Ernest G. McKay, Arnot Ogden Memorial Hospital, Elmira; New Jersey, Dr. George O'Hanlon, Jersey City Medical Center, Jersey City.

East North Central States: Ohio, A. E. Hardgrove, City Hospital, Akron; Indiana, Albert G. Hahn, Protestant Deaconess Hospital, Evansville; Illinois, Maurice Dubin, Mount Sinai Hospital, Chicago; Michigan, Robert G. Greve, University Hospital, Ann Arbor; Wisconsin, Rev. Herman L. Fritschel, Milwaukee Hospital (Passavant), Milwaukee.

West North Central States: Minnesota, A. M. Calvin, Midway and

Mounds Park Hospitals, St. Paul; Iowa, E. C. Pohlman, University Hospitals, Iowa City; South Dakota, Mabel O. Woods, Methodist State Hospital, Mitchell.

South Atlantic States: Delaware, C. A. Hume, Delaware Hospital, Wilmington; Maryland, John E. Ransom, Johns Hopkins Hospital, Baltimore; Virginia, Dr. Lewis E. Jarrett of the hospitals of the Medical College of Virginia, Richmond; North and South Carolina, Graham Davis, Duke Endowment, Charlotte, N. C.; Georgia, J. B. Franklin, Grady Hospital, Atlanta.

East South Central States: Kentucky, Lake Johnson, Good Samaritan Hospital, Lexington; Tennessee, Dr. Eugene B. Elder, Knoxville General Hospital, Knoxville; Alabama, Dr. Neal N. Wood, Hillman Hospital, Birmingham.

West South Central States: Arkansas, Lee C. Gammill, Baptist State Hospital, Little Rock; Louisiana, Mrs. Janet Korngold, Touro Infirmary, New Orleans; Oklahoma, R. L. Loy, Jr., Oklahoma City General Hospital, Oklahoma City; Texas, Elizabeth Kelly, Sealy Hospital, Santa Anna.

Mountain States: Colorado, William S. McNary, Colorado School of Medicine and Hospitals, Denver; Arizona, J. O. Sexson, Good Samaritan Hospital, Phoenix; Utah, H. S. Barnes, Latter-Day Saints, Salt Lake City.

Pacific States: Washington, Dr. A. C. Jordan, King County Hospital Unit 1 (Harborview), Seattle; Oregon, Carolyn E. Davis, Good Samaritan Hospital, Portland; Northern California, E. L. Slack, Samuel Merritt Hospital, Oakland.

Canadian Provinces: Alberta, Dr. E. A. Braithwaite, Alberta Department of Public Health, Edmonton; British Columbia, J. V. McVety, British Columbia Hospitals Association, Vancouver; New Brunswick, Dr. S. R. D. Hewitt, St. John General Hospital, St. John; Ontario, Dr. Fred W. Routley, Ontario Hospital Association, Toronto; Quebec, Dr. John C. Mackenzie, Montreal General Hospital, Montreal; Saskatchewan, Leonard Shaw, Saskatoon City Hospital, Saskatoon; Newfoundland, Dr. John M. Olds, Notre Dame Hospital, Twillingate.

Amend Insurance Laws for Group Hospitalization

The Georgia Hospital Association is sponsoring a bill to amend the state insurance laws to permit group hospitalization, and Tulsa, Okla., is studying the system instituted in Oklahoma City a year ago, with the idea of trying it.

The present Georgia insurance laws prohibit group hospitalization by classifying it as insurance and requiring hospitals to comply with all insurance laws, including a heavy guarantee to the state. The amendment, which the association feels confident will be passed, will eliminate these difficulties, and permit group hospitalization. Effort is also being made to amend the Georgia compensation law to increase the benefits for medical, nursing and hospital service from \$100 to an adequate amount.

The Oklahoma City corporation, which is known as Hospital Mutual, Inc., now has 1,400 subscribers and a reserve fund of about \$1,500. Certificates in this organization sell for nine dollars a year or seventy-five cents a month. The hospitals in the association are Wesley, Samaritan and Oklahoma City General.

\$60,000 to Petersburg Hospital

The bulk of the estate of the late Thomas F. Knock, valued at about \$75,000, has been left to the Petersburg Hospital, Petersburg, Va., of which Montez Wayne is superintendent. Personal bequests amounting to about \$15,000 must be paid before the hospital receives the balance of the estate.

X-Ray Separator Permits Division of Rays for Study

A "separator" that will permit the study of each of the more penetrating wave lengths of the x-ray has been developed after fourteen years of research at Cornell University, under the direction of the physicist, F. K. Richtmyer, dean of the graduate school. This apparatus, which is described as a two crystal transmission spectrometer for ultra-short x-rays, is said to open up a field that is entirely new in medical science.

It has been known for some time that the softer or less penetrating wave lengths of the x-ray have a destructive effect on the tissues of the skin that the more penetrating ray lacks. These softer rays, however, can be filtered out by the use of screens and their harmful effect on the tissues of the skin can thereby be avoided.

Sunlight is a composite of the seven colors of the visible spectrum, plus the infra red and ultraviolet rays, with each having a different wave length. X-rays are similar, but it has never before been possible to separate the short wave length components of the powerful x-ray tube into individual wave lengths, thus it has never been determined whether some rays in the short wave region have a different effect upon living tissues than others.

The separator will enable medical science to learn what specific types of wave lengths are most beneficial in the treatment of a certain disease. The shorter wave lengths ordinarily used in medicine are from one to one-tenth angstrom units, but the new giant x-ray tubes of 1,000,000 volts generate wave lengths in the region of from one-tenth to one-hundredth of an angstrom unit. It is for these tubes that the sievelike apparatus was devised.

Gelatine ADDS VARIETY

TO THE DIET AT MURRAY HILL HOSPITAL

"It often requires variety to tempt the appetite of the sick," says Miss Snell, Chief of Dietetics at Murray Hill Hospital, N. Y. C. "That is why I find gelatine such a help when it comes to arranging diets for patients here. It simplifies the problem of serving something which will stimulate the desire to eat and which will be at the same time easily digested."

This is one of Miss Snell's favorite recipes for diabetic patients

JELLIED MUSHROOMS FOR COLD MEAT

	Grams.	Prot.	Fat	Carb.	Cal.
2 cups mushrooms sliced thin
2 cups hot water
1 teaspoonful salt
1 envelope Knox Sparkling Gelatine	7	6
1/4 cup cold water
1 teaspoonful lemon juice
<i>Total</i>	...	6	25
<i>One serving</i>	...	1	5

Cook mushrooms in hot water and salt until tender, then drain off water and save for jelly. Pour cold water in bowl and sprinkle gelatine on top of water. Add to hot liquid from mushrooms and stir until dissolved. Add lemon juice and chill. When nearly set, stir in cooked mushrooms, mold and chill until set.



When using gelatine in the diet for the sick, be sure it is a U.S.P. gelatine or better. Knox Gelatine is free from all pathogenic, gas, or acid-forming bacteria. It contains no carbohydrates . . . sugar content of recipes is completely under control of user. As carefully made and supervised as an

ampule solution. Gelatine does add variety to the hospital regimen, as well as nourishment and sparkle. An easily assimilated protein for convalescent, tubercular, post-operative, and diabetic. Also excellent in infant feeding and in cases where high protein diet is desirable.

PREFERRED BY HOSPITAL AUTHORITIES

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KNOX GELATINE LABORATORIES, 465 Knox Avenue, Johnstown, N. Y.
Please send me FREE your booklets, "Feeding Sick Patients," "Feeding Diabetic Patients" and "Reducing Diets."

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F. H. Martin, Founder of College of Surgeons, Dies

Dr. Franklin H. Martin of Chicago, founder and director general of the American College of Surgeons and internationally known as an author and editor, died in Phoenix, Ariz., March 7, of a heart attack. He was seventy-seven years of age.

Doctor Martin, one of the leading surgeons and gynecologists in the United States, was born on a farm at Ixonia, Wis., and obtained his first medical degree at the Chicago Medical College, which has since become the medical school of Northwestern University, Chicago.

In 1888 he organized with Dr. W. F. Coleman the Postgraduate Hospital School of Chicago, and from that time devoted himself to educational work and the practice of gynecology. He published a number of monographs in this field, including one on "Treatment of Fibroid Tumors of the Uterus," in 1897 and "Treatise on Gynecology," in 1903.

His most important work began in 1905 with the publication of the periodical, *Surgery, Gynecology and Obstetrics*, to which in 1913 was added the *International Abstracts of Surgery*. The development of this publication led to the formation of the Clinical Congress of Surgeons of North America in 1910 and eventually to the American College of Surgeons in 1913.



Associated with him in this work were Drs. William J. Mayo, A. J. Ochsner, John B. Murphy and George W. Crile.

During the World War Doctor Martin was asked to head the development of medical participation. He was chairman of the general medical board of the Council of National Defense and a member of the executive committee under which state and county committees of medical men were organized. He developed the Volunteer Medical Service Corps in which numbers of American physicians enrolled. During this period he became a colonel in the medical corps of the United States Army and served with the American

Expeditionary Forces for three months.

Director general of the American College of Surgeons from its organization in 1913 until his death, Doctor Martin initiated and directed the movement for the standardization of hospitals, bringing into this work in the first instance, Dr. John G. Bowman, and later, Dr. M. T. MacEachern.

He edited *Surgery, Gynecology and Obstetrics* continuously until his death, when, according to an agreement between Dr. and Mrs. Martin and the College, made in 1932, the periodical becomes the property of that organization.

He was president of the American College of Surgeons in 1929, president of the International Association of Gynecologists and Obstetricians in 1919, trustee of Northwestern University from 1921 to 1931, and founder and leader of the Gorgas Memorial Institute of Tropical and Preventive Medicine.

Two Regulations Amend Alberta Hospital Act

The Hospitals Act of the Province of Alberta, Canada, has been amended by the following regulations:

"61. The Hospitals Board shall see that every nurse in training, every attendant and every new graduate taken on the staff, is given a complete physical examination, including an x-ray examination of the chest, before the nurse in training, the attendant, or the graduate nurse is accepted or placed on duty.

"In the case of the nurse in training and the attendant, a complete physical examination, including an x-ray examination of the chest, shall be made at least once every twelve months throughout the period of training.

"46. Tissues or sections of tissues removed at operations shall immediately be set aside by the surgeon operating, and shall be forwarded by the superintendent to the Provincial Laboratory for examination, or to a laboratory approved by the Provincial Laboratory, together with a short statement giving the findings at the operation."

Work Starts on County Hospital

Contracts have been awarded for the Aiken County Hospital, Aiken, S. C., and construction will be started at once. The building is being financed by a PWA allotment of \$158,000.

National Hospital Day Is Commended by Roosevelt

Albert G. Hahn, chairman of the National Hospital Day Committee of the American Hospital Association has received the following letter from President Roosevelt regarding National Hospital Day:

"My Dear Mr. Hahn:

"The hospitals of the nation constitute our most important agencies in relieving the suffering of our people incident to the ills and injuries to which they are inevitably subjected. Almost every man, woman, and child in our land at one time or another must have the care and treatment hospitals afford.

"Our country is fortunate in having a large number of well equipped hospitals ably managed, and staffed with highly efficient professional experts. The relationship between these institutions and the people should be intimate and sympathetic.

"The American Hospital Association is to be highly commended for designating a National Hospital Day, a day upon which the hospitals of the country will welcome the people of their respective communities within their doors as guests. I trust that our people will take this opportunity to secure first hand knowledge of the hospitals of the nation and the vast human service they are rendering.

"Very sincerely yours,
(Signed) FRANKLIN D. ROOSEVELT."

Colorado Association Gets Report on Legislature

One of the most important features of the program at the Colorado Hospital Association which met in Denver on Tuesday, March 5, was the report given by Walter G. Christie, superintendent of the Presbyterian Hospital and chairman of the legislative committee, in which he said that a financial responsibility law for motorists and an impostor's law, providing a penalty for intentional fraud on hospitals would be passed by the state legislature.

Clinical conferences for interns were discussed by Dr. Thaddeus P. Sears, president of the staff of the Denver General Hospital, who has organized conferences among the interns at his hospital that have been the object of much favorable comment.

A paper on Colorado's tuberculosis problem and proposed legislation by Dr. B. B. Jaffa, coroner of the city and county of Denver, brought the program to a close.

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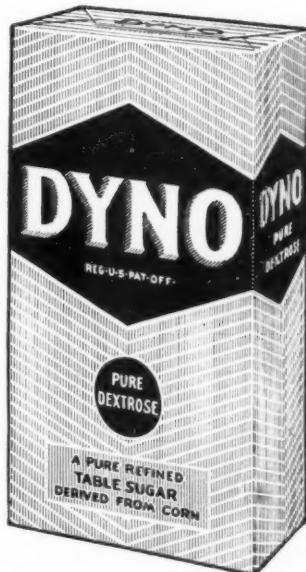
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Start Drive to Establish Free Mental Hospital

Efforts are being made to organize a drive for \$200,000 with which to establish a hospital for the free treatment of mental cases in New York City.

This movement is being sponsored by the auxiliary of the Body and Mind Foundation, Inc., a group of friends, patients and former patients of Dr. Edward Spencer Cowles, psychiatrist and neurologist, who conducts his own hospital in New York City and already has a free clinic. One of the primary fields for such a hospital, it is explained, lies in the treatment of such mental ills as "depression shock," maladjustment suffered by thousands as a result of the depression.

The sum of \$200,000, it is said, would equip a hospital sufficiently large to allow free treatment of urgent mental cases, while service could be expanded by charging fees to those able to pay.

Poems of Dr. Brush Published

Dr. Frederic Brush, medical director, the Burke Foundation, White Plains, N. Y., has recently brought forth another book of poems. This one, entitled "Crooked River," has sections called "Upland Songs," "Sidehill Tales," and "Downstream." The blurb states that "the experience and knowledge of men which Dr. Frederic Brush has gained firsthand as physician, teacher, author, administrator, wartime naval officer, hunter and athlete and which were evidenced in his previous narrative poem, 'The Long Hills,' have been successfully instilled into 'Crooked River.'" The volume is published by David McKay Company, Philadelphia.

Medical and Hospital Groups Confer on X-Ray Costs

A joint meeting of the California Medical Society and Western Hospital Association committees on x-ray departments, met in San Francisco, March 1, and drew up the following recommendation:

"It is the judgment of this joint committee that the practice of radiology and the practice of clinical pathology are in every particular integral parts of the practice of medicine.

"That it is necessary that a hospital operating a department of radiology and clinical pathology is entitled justly to (a) a sum which is adequate rental for the space occupied, (b) reasonable amounts for depreciation and obsoles-

cence, (c) all necessary costs accrued in the operation of such departments, (d) a reasonable return on its invested capital, and (e) a reasonable amount over and above these charges to create a sinking fund against contingency.

"That the compensation of the roentgenologists and pathologists shall be all the monies received by their respective departments over and above the admitted fixed charges enumerated above. Collection and distribution of fees to be by method agreed upon between the executive of the hospital and the roentgenologist and/or pathologist.

"That employees serving the department of roentgenology or pathology will be considered as a part of the staff of the hospital, subject to similar executive control as may be applied to other employees but professionally responsible to the roentgenologists or pathologists serving in charge of the respective departments; employees in the departments to be removed for cause upon recommendation of the head of the department."

Rebuild Hospital Destroyed by Fire

Plans for rebuilding the William Mason Memorial Hospital, Murray, Ky., are rapidly taking shape. The seventy-five-bed hospital was destroyed by fire in February and the loss, which was estimated at \$175,000, was only partially sustained by the \$66,000 insurance coverage carried by the hospital. A construction fund was started by the Mayo Brothers, Rochester, Minn., who contributed \$15,000. The townspeople of Murray have raised an additional \$10,000, and the fund is still growing.

California Hospitals Organize

The newly organized Association of California Hospitals elected officers for the year when the group held a meeting at the time of the Western Hospital Association convention in San Francisco, which took place in February. R. E. Heerman, California Hospital, Los Angeles, was named president and Mrs. L. M. Armstrong, of *Western Hospital Review*, secretary.

New York to Have Group Hospitalization; Frank Van Dyk Named Executive Head

A nonprofit corporation which will operate a plan for group hospitalization has been organized under the sponsorship of the United Hospital Fund and will be known as the Associated Hospital Service of New York.

Frank Van Dyk, organizer and manager of the associated hospitals of Essex County, Newark, N. J., has been named executive head of the service. Mr. Van Dyk, who has been a specialist in hospital financing for the last twelve years and is a recognized authority on the group payment plan, will begin work with the New York organization early this month.

Subscriptions of ninety cents a month or ten dollars a year from each person joining the organization, will be made into a fund to purchase hospital service whenever it is needed. All voluntary hospitals in New York City and the metropolitan area approved by the American College of Surgeons are eligible for membership, and certain proprietary hospitals maintaining similar standards will be admitted.

Membership entitles the subscriber to three weeks' hospitalization, and admission to a hospital will be granted on the recommendation of the member's personal physician. The patient admitted will be subject to the regular

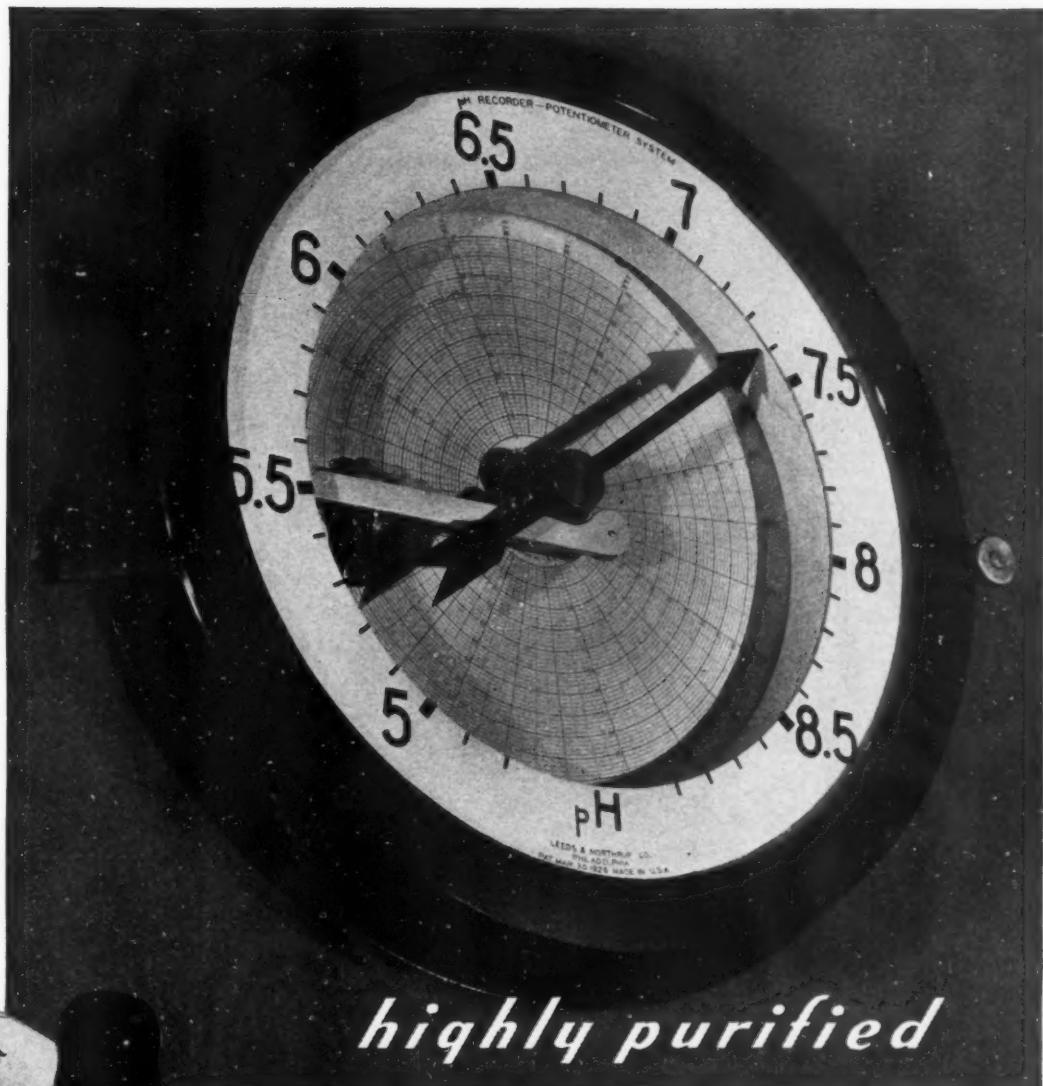
rules of the hospital, and arrangements in respect to fees for medical and surgical service must be made between the patient and his own physician.

Solicitation of memberships will be undertaken among employed groups, and arrangements made for pay roll deductions of the fee. The hospital service plan has been endorsed by the Medical Society of the State of New York, the American Hospital Association and the American College of Surgeons.

Karl Eilers, president of Lenox Hill Hospital, is president of the service. Dr. Walter T. Dannreuther, former president of the New York County Medical Societies, and Stanley Resor, vice president of the Manhattan Eye, Ear and Throat Hospital, are vice presidents, and Homer Wickenden, general director of the United Hospital Fund, is secretary.

Included among the directors are Dr. S. S. Goldwater, hospital commissioner of New York City, Dr. T. Dwight Sloan, superintendent of New York Post-Graduate Medical School and Hospital, David H. McAlpin Pyle, president of the United Hospital Fund, and the Rev. Joseph F. Brophy, director of the health division of the Catholic Charities Archdiocese of Brooklyn.

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A S Q U I B B G L A N D U L A R P R O D U C T

Use of Pulmotor and Lungmotor Condemned

Edward Steidle, dean of the school of mines and metallurgy, Pennsylvania State College, State College, Pa., writing on practical aspects of resuscitation says that as early as 1914 the United States Bureau of Mines and the United States Public Health Service tested and condemned the use of both the pulmotor and the lungmotor for administering artificial respiration.

These two bureaus do not approve of any positive pressure device for administering artificial respiration. In the course of exhaustive investigation it was found that mechanical devices of this character do not conform to natural breathing, on the other hand they disturb the natural rhythm of breathing which is controlled by carbon dioxide in the different portions of the lung cells.

Furthermore, it was found that the excessive pressure and suction developed by mechanical devices in due time rupture the delicate lung tissue and actually do more harm than good.

Bill Would License Technicians

A bill to license clinical laboratory technicians has been introduced into the California legislature. The bill would prohibit any person, except licensed physicians, from performing any test for an infectious or contagious disease, or any test on a person who might have such a disease, without a license from the state board of public health. The board is empowered to conduct examinations in any way it may prescribe. An examination fee of five dollars is set and an annual license fee of one dollar.

Central Index Bureau Is Montreal Experiment

A central index bureau, where every out-patient of a hospital in Montreal, Que., will be registered, is being tried by the department of health of Montreal in conjunction with the hospitals of the city.

The object of the bureau is to relieve hospitals of the burden of keeping extensive out-patient files, to regulate the attendance at clinics and to protect members of the medical profession from exploitation of the free clinic by persons able to pay a family physician.

It is thought that this index will eliminate some of the chronic sufferers who shop from hospital to hospital.

Any hospital in the group may communicate with the bureau, trace a patient's record and refer him to his original hospital for treatment. Duplicate records will thus be avoided.

If a hospital, at the time a patient presents himself to the out-patient department, becomes suspicious of the patient's rights or need of free treatment it may report the case to the bureau. A city investigator will be sent to the home of the patient and a report made to the hospital.

Oregon Group Elects Officers

Rev. Axel M. Green, superintendent, Emanuel Hospital, was reelected president of the Oregon State Hospital Association at a recent meeting of the association in Portland. Carolyn E. Davis, superintendent, Good Samaritan Hospital, was chosen vice president and Grace Phelps, superintendent, Doernbecker Memorial Hospital for Children, was elected secretary. All are of Portland.

Legislatures in Tennessee and Texas to Regulate Practice of Nursing

The Tennessee legislature has passed an act to regulate the practice of professional nursing, the use of the term, "graduate nurse," and the issuance of certificates to nurses, while the Texas legislature is now considering a bill which defines an accredited school of nursing and prescribes the necessary qualifications of applicants for the certificate of registered nurse.

The newly passed Tennessee act provides for a committee on nursing education and nursing practice to be appointed by the governor, which will carry out the purposes of the act. The secretary of the committee will issue certificates and annual validation cards.

A nurse, over twenty years of age, with a preliminary education of at least four years of high school or its equivalent, who holds a diploma from a school of nursing giving a course of not less than two years, may apply to the secretary for registration, and upon payment of ten dollars will be entitled to take the examination. If the applicant passes the examination and is given a license to practice, no further license fee shall be required of her during the current year.

An applicant who conforms to the requirements and successfully passes an examination will be issued a certificate that permits the use of R.N. The holder of a certificate of registered nurse on July 1, 1935, need not take the examination. The license of each registered nurse in Tennessee must be renewed annually on or before September 1, and the renewal fee will be one dollar. Failure to renew a license automatically forfeits the right to practice in the state.

The secretary, upon written application and receipt of a license fee of ten dollars, may issue a license without examination to any nurse who has been

licensed to practice in another state where the requirements are similar, if that state recognizes the certificates issued in Tennessee. This reciprocity clause is the first that the state has had in the nursing field.

The act does not affect nurses who at the time it was passed were registered nurses, except as to the requirement for annual validation of the original certificate. It also does not prevent any person from performing the duties of a practical nurse, or those carried on by an attendant or nurse in a doctor's office.

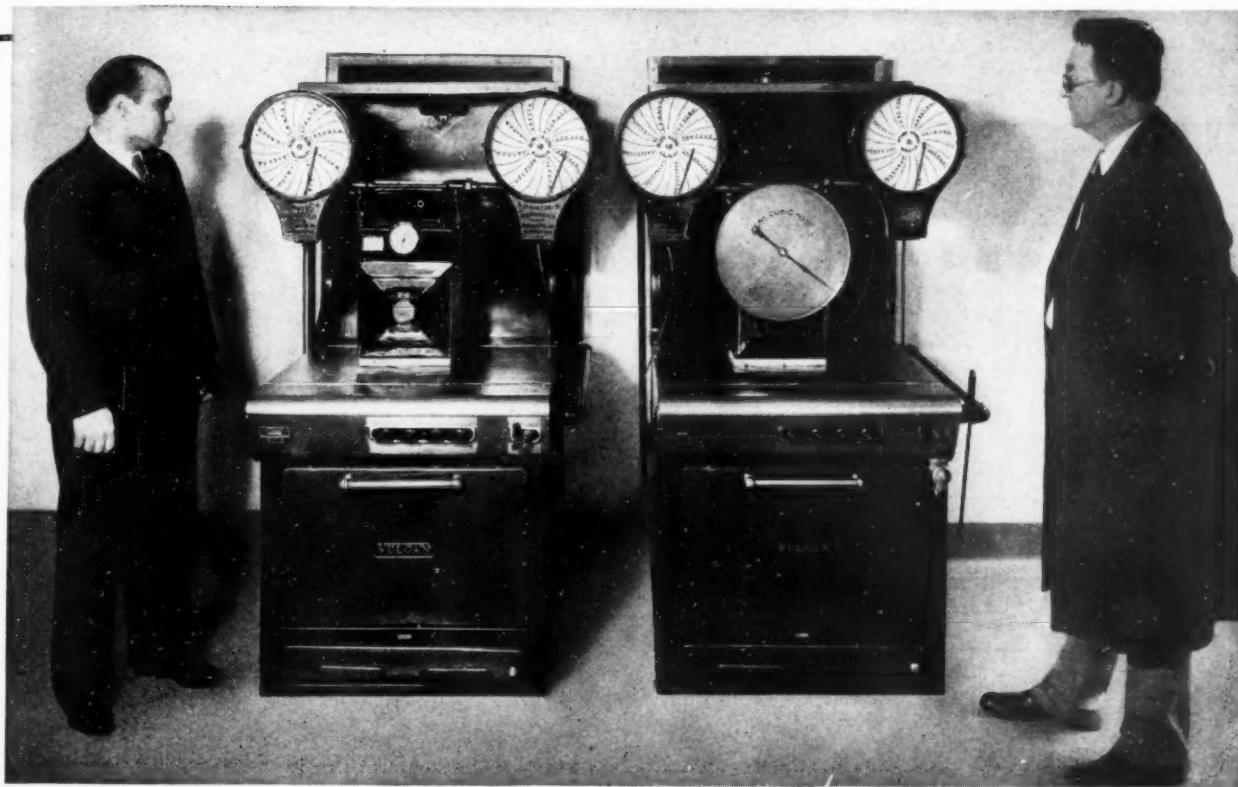
The bill now pending before the Texas legislature defines an accredited nursing school as one connected with a general hospital of not less than twenty-five beds and a daily average of not less than fifteen patients annually. The school must be presided over by a nurse registered in the state, and must teach the course of study designated by the state board of nurse examiners.

Applicants for registration must have had three years' continuous training in an accredited school of nursing, and no person may be certified as a graduate of any such nursing school unless she has had three full years of work and study in an accredited school, two years of which must be continuous in the school from which she has graduated, or she may have two continuous years of work and study in a special hospital and one continuous year in a general hospital.

A general hospital, as used in the bill, "is a public or private institution where men, women and children are treated for all kinds of diseases, bodily injury, or physical deformity by means of both medical and surgical treatment, and which maintains an organized staff of physicians and surgeons licensed to practice medicine in the state of Texas."

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Varied Program Planned for Tri-State Meeting at Greensboro, N. C., April 11-12

The fifteenth annual tri-state convention of the North Carolina Hospital Association, the South Carolina Hospital Association and the Virginia Hospital Association is to be held in Greensboro, N. C., April 11 and 12.

The Thursday morning program is devoted to small hospitals, primarily, and M. O. Fletcher, manager, Tayloe Hospital, Washington, N. C., will discuss the small hospital as a community asset, while Dr. Robert W. Petrie, Petrie Hospital, Murphy, N. C., will present a few administrative problems of the small hospital. Dr. Lewis E. Jarrett, secretary of the Virginia Hospital Association, will close the morning program with a talk on the personal side of the hospital. Dr. Newton Fisher, president of the North Carolina association will preside at this opening session.

The North Carolina Workmen's Compensation Act and hospital claims allowed by it, will be discussed on Thursday afternoon by John C. Root, chief claim examiner of the North Carolina Industrial Commission. J. Ly-

man Melvin, superintendent, Park View Hospital, Rocky Mount, N. C., will talk on hospital publicity, and B. W. Rogers, business manager, Watts Hospital, Durham, N. C., will present the problems confronting the larger hospitals giving private service in conjunction with free service.

The address at the banquet on Thursday evening will be given by Robert E. Neff, president of the American College of Hospital Administrators. His subject is "Hospital Administration and Administrators."

Among the speakers scheduled for the program on Friday morning are Dr. J. J. Shackleford, Shackleford Hospital, Martinsville, Va., on "Some Thoughts Concerning the Medical Department of a Small Hospital," Helen Robb, Johnston-Willis Hospital, Richmond, Va., on "Modified Central Tray Service," and Ruth Council, president, North Carolina Nurses Association, who will discuss the subject of nursing education.

On Friday afternoon Dr. F. H. Mayfield, member of the neuro-surgical

service, hospital division, Medical College of Virginia, will open the program with some helpful hints on operating room management. Legislation for hospitals is the subject of the talk to be given by Dr. John S. Bradway, director of legal aid clinic, Duke University. Dr. I. H. Manning, Chapel Hill, N. C., will conclude the afternoon session with a discussion of the group payment plan for hospital care.

Separate business meetings of the three associations will be held immediately after the talk by Doctor Manning, which closes the convention.

Work on Details of Group Payment Plan

Legislation affecting hospitals, current and pending, was the subject of most interest brought before the March 6 meeting of the South Carolina Hospital Association in Columbia, S. C.

A committee to work out details of a statewide plan for group payment was appointed, with Dr. James McLeod, assistant superintendent, McLeod Infirmary, Florence, as chairman, assisted by Dr. Robert Abel, former president of the Medical Society of South Carolina; Dr. J. M. Beeler, superintendent, Spartanburg General Hospital, Spartanburg; C. H. Dabbs, superintendent, Tuomey Hospital, Sumter; Mrs. Byrd B. Holmes, superintendent, Greenville City Hospital, Greenville, and W. M. Whiteside, superintendent, South Carolina Baptist Hospital, Columbia.

Graham L. Davis, of the hospital section of the Duke Endowment, after inviting the association to attend the Tri-State Hospital Convention at Greensboro, N. C., April 11-12, spoke on the group payment plan sponsored by the North Carolina Hospital Association. He also emphasized the value of ethical publicity to the hospital, and pointed out that while in comparison to other states, South Carolina needed more hospitals, those that it had were inadequately supported.

Group Insurance to Be Compulsory

Compulsory group insurance for all city employees, including those of the Grady Hospital, with an income of not less than sixty dollars a month, has gone into effect in Atlanta, Ga., with the passing of a law to that effect by the Georgia General Assembly at the request of the city. The amount of insurance permitted is \$1,000 and the rate, seventy cents a month. The law went into effect on the first of March.

City Hospitals Centralized in Welfare Island Project

The first step in rebuilding Welfare Island into a refuge for New York City's indigent sick, with accommodations for 7,000 patients and housing for a resident staff of 3,500 was taken when the committee on city planning recommended to Mayor F. H. La Guardia that the entire island be transferred to the department of hospitals.

At present the island is used by both the department of hospitals and the department of correction. The hospital buildings are antiquated and able to accommodate but 5,000 patients, and so long as the rest of the island was used for prisons the necessary expansion of the hospital group has been impossible.

When the prisoners have been removed, work will start upon reclaiming that portion of the island where they are now housed. Plans submitted by Dr. S. S. Goldwater, commissioner of hospitals, calling for the expenditure of \$15,000,000 for the complete unit have been approved by the mayor, and requests for PWA funds to carry them out are now in Washington.

The first hospital will be begun dur-

ing the summer, and work will probably be started on the second before the end of the year. Patients will be moved into the new buildings immediately upon completion. This unit will permit the centralizing of all chronic cases and will aid in the development of research on chronic disease.

Offers Course in Psychiatric Nursing

A course in psychiatric nursing, first instituted at St. Francis Hospital, Pittsburgh, in January, is progressing satisfactorily with the result that another class of the same character will be organized for next July. This consists of a six months' course in theory and practice in the nursing of psychiatric patients available to graduates of accredited schools of nursing who are able to furnish required credentials. A matriculation fee of \$10 is required when the applicant is notified of acceptance. St. Francis Hospital is well equipped for this service because of its background of sixty-five years in caring for the mentally ill of Pittsburgh and the surrounding country. It is a 500-bed general hospital of which the psychiatric division is a unit, with a daily average of 185 patients.



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LONG ISLAND CITY, N. Y.

Research Division Planned for New York City Hospitals

A research division for the hospital system of New York City with the primary motive of aiding the chronically ill, is being planned by Dr. S. S. Goldwater, commissioner of hospitals.

In order to carry out this work, he has asked that one cent out of every dollar budgeted for his department for 1936 be set aside for research work. At least half the patients in municipal hospitals, he pointed out, are suffering from chronic diseases, and this division will work toward finding methods to alleviate the pain of the patients if not to cure them.

Previously this field has been neglected, partly because of the poor research facilities in municipal hospitals, and also because the voluntary hospital, which has the necessary laboratories and equipment, seldom handles this type of case.

In order to push this plan further, Doctor Goldwater is organizing a council, composed of laymen and physicians, that will promote scientific research in medicine, particularly in the field of chronic disease. This council will handle publicity, voluntary funds, and its executive committee, composed of physicians will have final approval of specific research projects.

N. Y. Dietitians Hold Annual Meeting

A large attendance contributed to the success of the annual meeting of the Greater New York Dietetic Association which was held at the Waldorf Astoria in New York City, in February. The guest speaker of the evening was Dr. William P. Murphy, recipient of the Nobel Prize in Medicine for 1934. Preceding his address, a reception was held in his honor.

36,000 Persons Killed by Motors in 1934

The highest automobile casualty toll ever recorded by the United States was made last year when 36,000 persons were killed and nearly a million injured in 882,000 personal injury collisions. In spite of the fact that most of these accidents were due to driving errors, the pedestrians had the highest death rate, with nearly 16,000 deaths.

Statistics compiled by the Travelers Insurance Company indicate that an increase in the number of cars driven was not responsible for the higher rate, since in 1931, which previously held the high record, there were 3 per cent

more automobiles registered and 1 per cent more gasoline used than in 1934.

The most important factor in this death rate seemed to be speed, as the casualty rate on highways was more than 100 per cent greater than the average of all other types of accidents combined, and death between intersections was 52 per cent higher than at intersections.

The rate of death per accident was 51.4 per cent higher during hours of darkness than during daylight, and considering the fact that night traffic is but one-fifth of all traffic, the rate of death during darkness actually becomes several hundred per cent higher than that during daylight. The evening rush hours, from five to nine exceed the morning rush hours, from six to ten, by a 289 per cent death rate. The death rate was the lowest during the morning hour between ten and eleven.

Laws Protecting Hospitals Before State Legislatures

It is called a "lien law" in Oklahoma, and a "New Garnishee Act and House Bill 387" in Indiana, while in South Carolina it is still merely a study being made by the state association, but it amounts to the same thing each time, a demand for protection of the hospital in the case of the automobile accident.

The lien law, which is now before the Oklahoma legislature provides for a lien in all cases for hospitals in the sum of five dollars a day, and the same amount for nurses, with a reasonable fee for practitioners. This lien may be claimed by filing an itemized account with the tort feasor and/or the insurance carrier by mail, or with the clerk in case suit is filed, setting forth the injuries of the patient.

There are two bills before the house in Indiana. One will permit the hospital to garnishee wages of employees who receive more than fifteen dollars a week and the other provides protection for the hospital in the case of auto accidents. The legal use of the garnishee act, it is thought, will make hospital collections easier, even though the act is used only as a threat.

In South Carolina it has been estimated that the cost to hospitals in automobile cases is annually \$80,000. The legislative committee of the state hospital association is making a study of this problem and will report on it, making recommendations at the joint meeting of the North Carolina, South Carolina and Virginia Hospital Associations to be held in Greensboro, N. C., April 11 and 12.

Patient Day Costs Vary in Pennsylvania

Patient day costs for 161 state aided hospitals in Pennsylvania for the quarter ending May 31, 1934, have just been released by the state department of welfare. They indicate quite a variation among the different hospitals included. Detail figures for various departments in 132 general hospitals, 8 teaching hospitals and 21 special hospitals are given as follows:

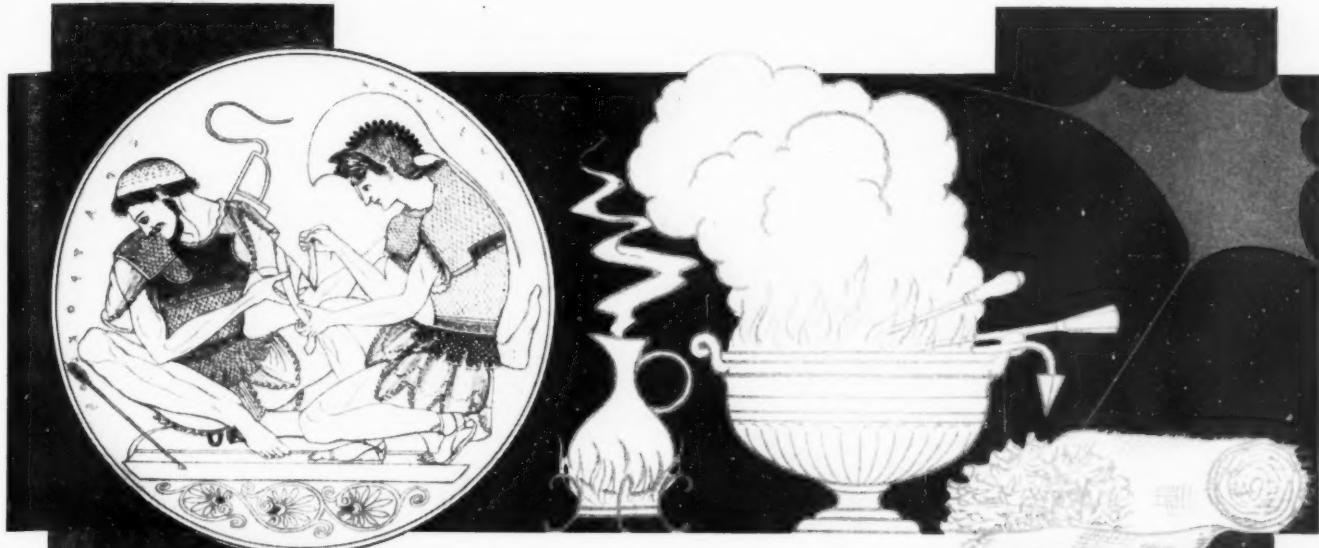
	<i>Gen.</i>	<i>Teach.</i>	<i>Special</i>
Housekeeping	\$0.26	\$0.28	\$0.24
Operation of plant	.42	.55	.44
Repair and upkeep	.23	.25	.19
Nurses' home	.04	.06	.04
Nursing	.55	.45	.51
Medical services	.06	.10	.10
Laundry	.15	.13	.11
Pharmacy	.12	.17	.07
Med. and surg. supplies	.18	.23	.08
Dietary	.86	.81	.74
Anesthesia	.07	.07	.03
X-ray	.15	.16	.07
Special therapy	.02	.05	.03
Laboratory	.14	.14	.10
Motor services	.02	.02	.01
Social services	.02	.04	.10
O. P. services	.06	.11	.15
Administration	.33	.29	.28
Commissary	.01	.03	.01
Fixed charges	.05	.03	.05
Total	\$3.74	\$3.97	\$3.35

Mental Patients Go in for Dramatics

A novel theatrical performance was given in a downtown theater in Cincinnati when patients in the Longview State Hospital for Mental Cases presented a minstrel show. The remarkable accomplishments in healing therapy were demonstrated by such features as a shell-shocked war veteran unable to pick up an object a few years ago who presented a juggling act, also a man convalescing from sleeping sickness who sang a solo. The production was directed by Edna G. Kirker, recreational director at the institution.

Dr. Bigelow's Body Found

The search for Dr. George H. Bigelow ended March 23 when his body was found in a reservoir and identified by Dr. M. J. Shaughnessy, medical examiner. Doctor Bigelow who was director of Massachusetts General Hospital, Boston, disappeared early in December and state police have been searching for him since that time.



THE shade of Ambroise Paré paused at the door and intently watched the nurse bending over her patient, deftly dressing a wound. "There," he heard her say, as she finished her task, "doesn't that feel better?"

His thoughts flew back to a night in the Alps four hundred years ago. He, himself, was stooping over a soldier, dressing a gaping wound. From a small brazier he selected a cautery and plunged it into the gash. The stench of burning flesh filled his nostrils. Replacing the iron he seized a flask of boiling oil. The soldier cried out in agony as the last few drops were poured into the wound and spread in hot rivulets over his leg. Still working rapidly Paré made a loose dressing of lint and rabbits' hair, bound it with coarse linen. Finished, he tossed the oil flask aside . . . Empty! . . . All he had . . . and these others needed help.

How well he remembered that night! Lacking oil, he hastily mixed a cold salve for the others. But he could not sleep, thinking of poison aggravating the pain of their wounds. What joy in the morning to find them better than those who had undergone the age-old treatment of cautery and hot oil—astounding!

Ambroise Paré was thoughtful as he followed the nurse to another room. Here he saw shelf upon shelf of lotions; soothing applications; soft gauze in a multitude of shapes and sizes; fluffy cotton in rolls and cartons and pellets; rolls and cubes of light, white, airy cellulose; bandages of all sorts; adhesives!

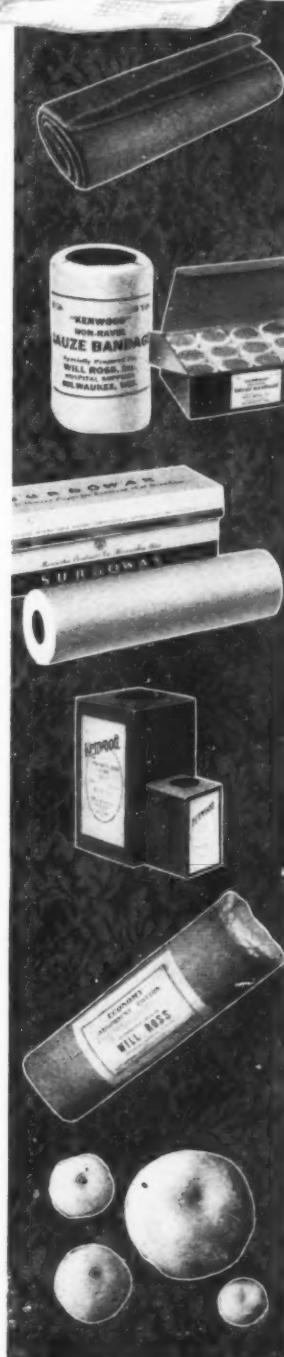
He moved over to the table at which she had begun to work. He touched the dressing she was preparing. Impressed, he lifted the upper layer of cellulose, his fingers drinking in its filmy softness. . . . Again the contrast of cobwebs and lint and rabbits' hair. . . . And they had called him a heretic when he advocated abandoning cautery and hot oil! Ambrose Paré smiled indulgently, released the sheet, watched it settle lightly . . .

But the nurse merely smoothed the vagrant sheet into place and wondered at the sudden breeze, for she could not know Ambroise Paré was there.



Yes, it is four hundred years since Ambroise Paré, the Great Surgeon, broke away from customs of surgical treatment that had been handed down through the ages, yet, it is only within the last half century that science has produced truly antiseptic dressings. And the history of Surgical Dressings, as we know them today, lies almost wholly in the present generation.

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Group Hospitalization Plans Arouse Public Interest

The welfare of hospitals is no longer the most important aspect of group hospitalization, according to C. Rufus Rorem, Julius Rosenwald Fund, Chicago, who spoke on this subject at a round table meeting in Chicago on February 19.

The center of interest now is the welfare of the public, Mr. Rorem stated. He declared that more inquiries are now coming to the American Hospital Association from civic leaders, women's clubs, industrialists, chambers of commerce and similar bodies than from hospitals. The idea, he said, continues to flourish but it flourishes most where the public's interest is given the most recognition.

Some group hospitalization plans have stopped growing while others are continuing to expand. Mr. Rorem re-

ported that the number of members in several plans at present is about as follows: Newark, N. J., 4,000; Cleveland, 6,000; Dallas, Tex., 18,000; Memphis, Tenn., 4,000; St. Paul, 3,000; New Orleans, 5,000; Wichita, Kan., 1,800, and Sacramento, Calif., 5,500.

The present pattern of group hospitalization is not yet of interest to the low wage earning groups, Mr. Rorem declared. A much lower rate must be set for them, a rate below \$5 a year, if they are to be included in any large numbers.

Dr. J. F. Kimball, vice president of Baylor University, Dallas, Tex., reported that experience with the Dallas plan indicated the following conclusions: (1) It is doubtful whether full coverage is desirable from the administrative point of view although no doubt valuable socially; (2) women cost nearly twice as much as men and unemployed dependent women cost

more than employed women; (3) dependents can be included if they also pay a share of the total cost.

Others reported that group hospitalization plans had seemed to have a beneficial effect on community chest collections in Cleveland rather than competing with them.

Chapel Built at Sea View

A chapel for the use of Sea View Hospital, Staten Island, N. Y., is being built in the center of the group of municipal buildings which comprise the hospital. The chapel, which has been named the Protestant Episcopal Chapel of St. Luke the Physician, will cost \$26,500. An anonymous bequest of \$18,000, and another donation of \$700 to be used for pews are partially defraying the expense. It is hoped to open the chapel Easter Sunday.

Coming Meetings

Ohio Hospital Association.
President, John R. Mannix, University Hospitals, Cleveland.
Executive secretary, A. E. Hardgrove, City Hospital of Akron, Akron.
Next meeting, Columbus, April 2-4.

Washington State Hospital Association.
President, Dr. K. H. Van Norman, King County Hospital, Seattle.
Next meeting, Seattle, April 6.

Joint Meeting North Carolina, South Carolina and Virginia Hospital Associations.
Greensboro, N. C., April 11-12.

Iowa Hospital Association.
President, Thomas P. Sharpnack, Broadlawns Hospital, Des Moines.
Secretary, Erwin C. Pohiman, University Hospitals, Iowa City.
Next meeting, Iowa City, April 29-30.

Joint Meeting Illinois, Indiana and Wisconsin Hospital Associations.
Chicago, May 1-3.

Arkansas Hospital Association.
President, Msgr. J. P. Fisher, Little Rock.
Secretary, Regina H. Kaplan, Leo N. Levi Memorial Hospital, Hot Springs National Park.
Next meeting, Little Rock, May 7.

Hospital Association of Pennsylvania.
President, Charles A. Gill, Episcopal Hospital, Philadelphia.
Executive secretary, John N. Hatfield, Pennsylvania Hospital, Philadelphia.
Next meeting, Philadelphia, May 8-10.

Michigan Hospital Association.
President, Dr. Warren L. Babcock, Grace Hospital, Detroit.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Next meeting, Jackson, May 9-10.

Mississippi Hospital Association.
President, Dr. R. J. Field, Field Memorial Hospital, Centreville.
Secretary, Dr. Leon S. Lippincott, Vicksburg Sanitarium, Vicksburg.
Next meeting, Biloxi, May 13.

New Jersey Hospital Association.
President, William J. Ellis, Trenton.
Executive secretary, Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark.
Next meetings, Cedar Grove, April 24, and Atlantic City, June 14-15.

International Hospital Association.
Next meeting, Rome, Italy, May 19-25.

Hospital Association of New York State.
President, P. Godfrey Savage, Niagara Falls Memorial Hospital, Niagara Falls.

Executive secretary, Carl P. Wright, General Hospital of Syracuse, Syracuse.
Next meeting, New York City, May 23-24.

National League of Nursing Education.
President, Effie J. Taylor, New Haven, Conn.
Executive secretary, Claribel A. Wheeler, 50 West Fiftieth Street, New York City.
Next meeting, New York City, June 3-8.

Mid-West Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June 6-7.

American Medical Association.
President, Dr. Walter L. Bierring, Des Moines, Iowa.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next session, Atlantic City, N. J., June 10-14.

Canadian Medical Association.
President, Dr. J. S. McEachern, Calgary, Alta.
General secretary, Dr. T. C. Routley, 184 College Street, Toronto, Ont.
Next session, Atlantic City, N. J., June 10-14.

Catholic Hospital Association of the U.S. and Canada.
President, Rev. Alphonse M. Schwitalla, S.J., St. Louis.
Executive secretary, M. R. Kneifl, 1402 South Grand Boulevard, St. Louis.
Next meeting, Omaha, Neb., June 17-21.

Minnesota Hospital Association.
President, J. H. Mitchell, Colonial Hospital, Rochester.
Executive secretary, A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul.
Next meeting, Duluth, June 20-21.

National Tuberculosis Association.
President, Kenyon Dunham, Cincinnati.
Managing director, Dr. Kendall Emerson, 50 West Fiftieth Street, New York City.
Next meeting, Saranac Lake, N. Y., June 24-27.

Hospital Association of Nova Scotia and Prince Edward Island.
President, Rev. H. G. Wright, Inverness, Nova Scotia.
Secretary, Anne Slattery, Dalhousie University, Halifax, Nova Scotia.

Next meeting, Wolfville, Nova Scotia, June, 1935.

Missouri State Hospital Association.
President, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June, 1935.

American Protestant Hospital Association.
President, Dr. Charles C. Jarrell, 405 Wesley Memorial Building, Atlanta, Ga.
Executive secretary, E. E. Hanson, Lutheran Deaconess Home and Hospital, Chicago.
Next meeting, St. Louis, Sept. 27-30.

American College of Hospital Administrators.
President, Robert E. Neff, University of Iowa Hospitals, Iowa City, Iowa.
Director-general, J. Dewey Lutes, Roosevelt Hospital, Chicago.
Next meeting, St. Louis, Sept. 29-30.

American Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston, Tex.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

American Public Health Association.
President, Dr. Eugene L. Bishop, Nashville, Tenn.
Executive secretary, Dr. Reginald M. Atwater, 50 West Fiftieth Street, New York City.
Next meeting, Milwaukee, Oct. 7-10.

American Dietetic Association.
President, Laura Comstock, Rochester, N. Y.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Cleveland, October 28-31.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Luke's Hospital, Davenport, Iowa.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28-Nov. 1.

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New Premium Rate for Group Payments Adopted

A new premium rate for group hospitalization contracts has been put into effect by the Baylor University Hospital, Dallas, Tex. The plan is designed to take care of the differences in groups different in size and in disease experience. It is hoped that it will furnish an incentive to each group to keep down its costs.

The basic dues are set at seventy-five cents a month for thirty-five days of hospital care and the usual "extras." Where, however, the funds are collected by a pay roll deduction and where a given percentage of the eligible personnel actually subscribe, a "company collection credit" of ten cents a month is allowed.

In addition to that an "experience credit" of up to fifteen cents a month is allowed for those groups which have below average illness rates. The "experience credit" is given provisionally and may be withdrawn when in the opinion of the hospital the record of the group no longer warrants such an extra credit.

Milbank Pleads for Physicians' Cooperation

A plea for cooperation between philanthropic foundations, social workers and organized medicine in an effort to solve the problem of payment for medical care was made in Indianapolis at the recent annual conference of secretaries of the county medical societies of Indiana, by Albert G. Milbank, New York City, president of the Milbank Memorial Fund.

"The doctor who contends that the whole field of health belongs exclusively to him," he said, "is on unsound ground. On the other hand, health foundations, public health leaders, social workers, and the voluntary agencies who fail to guard the rightful private interests of the practicing physician are acting unwisely and retarding their own efforts."

Mr. Milbank said that the staff of the Fund was making an investigation of various methods of health insurance in use in the United States and abroad, and he frankly admitted that unless great care were taken in the administration of a health insurance system, it might be open to the abuses of bureaucracy and political influence.

Some of the important features embodied in the proposals of the Milbank staff are: safeguards to maintain the present personal relationship between

doctor and patient; freedom of practitioners to accept or reject patients; no interference by the insurance system with private purchase of medical care by those who can afford it; freedom of all competent practitioners to engage in insurance practice, and professional control of professional personnel and procedures.

Mr. Milbank urged that the problem be given dispassionate consideration, and said that if the doctors themselves participated whole-heartedly in the formulation of the health insurance program it could become a success.

New Quarters for X-Ray Department at Berkeley

New quarters are being arranged for the x-ray department of Berkeley General Hospital, Berkeley, Calif., in the east wing of the building where 1,371 square feet of floor space has been turned over to the department.

When completed the x-ray department will have a room for radiographic work, one for deep therapy, one for fluoroscopy, one for cystoscopy, a viewing room, a developing room, a plaster cast room, three dressing rooms, a waiting room and a storage vault.

New x-ray apparatus equipped for full wave ultra rapid diagnostic work and both light and deep therapy has been installed, as has a flat top bucky table which will permit the taking of x-ray pictures of any section of the body without adjusting the patient's position.

A surgical thermo unit with a radio knife for use in bloodless surgical procedures has been installed on trial.

Hospital Council Organized

The newly organized Hospital Council of Boston, with a membership of eighteen hospitals, drew up by-laws and elected officers at a meeting at Beth Israel Hospital on March 11. The council, which was organized under the supervision of the Local Medical Superintendents' Club, is being financed by the allocating committee of the recent emergency campaign.

Move Into New Building

The Baltimore City Hospitals, Baltimore, have moved into the new million dollar clinical building recently completed for their use. It has accommodations for 120 medical, 120 surgical, 100 obstetric and 60 pediatric patients. Parker J. McMillin is superintendent of the hospitals.

Tuberculosis Campaign

Based on Modern Methods

"Fight Tuberculosis With Modern Methods," is the slogan of the 1935 Early Diagnosis Campaign to be inaugurated April 1 by official and voluntary health agencies throughout the country.

The campaign this year is directed toward placing before the public information regarding tuberculosis treatment, particularly with reference to the newer techniques.

Leaflets, posters, and other publicity material are being distributed by local tuberculosis and public health associations.

Leaves \$2,000,000 for Research

The University of Pennsylvania will receive about \$2,000,000 for general surgical research under the will of the late George Leib Harrison. The endowment is to be known as "The George L. and Emily McMichael Harrison Memorial Fund for General Surgical Research," and the income is to be used for the research department in connection with any one or more or all of the hospitals and laboratories of the university. An additional \$135,500 was divided among charitable institutions and the rest of the \$3,000,000 estate was left to friends and relatives.

N. Y. Hospitals Get Bequests

Several New York hospitals are mentioned in the will of Mrs. Mary Strong Shattuck, who died in New York recently. St. Luke's Hospital of that city receives \$25,000 in memory of Mrs. Shattuck's father, the late Mayor William L. Strong, also \$15,000 in memory of her mother. Bellevue Hospital, Broad Street Hospital and the Woman's Hospital received bequests of \$25,000 each.

St. Luke's benefits also under the will of Juliet C. Smith, New York City. The hospital receives the residuary estate valued at "more than \$20,000." The gift is made for the endowment of a private room for the use of needy clergymen of the Protestant Episcopal Church and members of their families, the income to be used for their care.

New Hospital at Lenoir

A twenty-four-bed hospital, two stories high, is being built at Lenoir, N. C., under the leadership of Dr. Verne H. Blackwelder. The architect is R. L. Clemmer of Hickory, N. C.

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Joint District Meetings of Societies Held Last Month

Joint district meetings of hospital groups and the American College of Surgeons were held last month at Birmingham, Ala., on March 7 and 8 and at St. Paul, Minn., March 15 and 16.

The St. Paul meeting drew superintendents, trustees and surgeons from Wisconsin, North and South Dakota, the Province of Manitoba, and Minnesota. B. J. Branton, superintendent of the Willmar Hospital and Clinic, Willmar, Minn., discussed the problems of hospitals in small towns and rural areas.

The Birmingham meeting was attended by representatives from Alabama, Georgia, Florida, Mississippi, Louisiana and Tennessee.

Study Food Costs and Rates for Indigents

Studies of hospital rates for indigent patients in the state of Iowa and increased costs in commodities were presented at the meeting of the Des Moines and Central Iowa Hospital Council held in Des Moines, Ia., on February 26.

R. A. Nettleton, superintendent of the Iowa Methodist Hospital, Des Moines, gave the following results compiled by him from questionnaires sent to all Iowa hospitals regarding the charge per day for the care of indigents, sent in by counties.

Cost per Day	Hospitals
\$5.25	1
4.00	1
3.50	1
3.00	1
2.85	2
2.57	1
2.50	9
2.43	1
2.35	3
2.29	3
2.25	3
2.15	4
2.00	14
1.75	3
1.50	3

Discount on Extras

60%	1
50%	20
33 1/3%	2
25%	7
20%	4
15%	1
10%	1
No discount	16
No charge	6
At cost	3

Whether these rates actually cover hospital costs could not be determined, since the amount and kind of service furnished were not considered. The

rates are arranged between county and hospital officials.

A schedule comparing the costs of commodities for the last three months of 1933 with the same period in 1934, presented by Mr. Woods of Mercy Hospital, Des Moines, showed an increase of from 5 to 23 per cent, or an average increase of 12 per cent in food costs while the cost of hospital supplies had increased from 10 to 30 per cent, an average increase of 20 per cent.

In connection with this report the manager of the Hotel Fort Des Moines, furnished a list of food products and their cost comparisons for January, 1934 and January, 1935, as compiled by the hotel staff. It showed the following increases:

Butter	80%
Milk	25%
Flour	13%
Eggs	120%
Fresh Fruits	20%
Lamb	25%
Fresh Vegetables	15%
Canned Vegetables	12%
Canned Fruits	20%
Poultry	50%
Beef Products	50%
Pork Products	75%

Construction Projects Go Forward in Virginia

A forty-two-bed addition to the Alexandria Hospital, Alexandria, Va., which will bring the capacity of the hospital to 100 beds is now under construction. The new unit includes a department for Negro patients, private rooms, a children's ward, and a new obstetric department. The addition will be ready for occupancy this spring. Fanny Carter is the superintendent of the hospital.

A three-story annex, designed by the George S. Rider Company, Cleveland, architects, will be built for the Chesapeake and Ohio Railway Hospital, Clifton Forge, Va., this summer.

The annex, which will accommodate fifty beds, will be erected in the rear center of the present building, and at the same time the hospital itself will be renovated and modernized. Bids on the annex were taken in March, and construction is expected to start in May.

Rates for Indigents Raised

The hospitals in Buffalo and Syracuse, N. Y., have had their rates for city and county patients raised by the welfare departments. In Buffalo the city rate went into effect in January and the county increased rate will take effect July 1.

Correspondence

Sirs:

Some time ago you discussed the fairness of the radiologists' claims against the hospitals. As I understand the situation, there are three plans which the roentgenologists are considering: (1) that the roentgenologist receive from the hospital a full time salary; (2) that the roentgenologist receive a certain percentage of the gross receipts from the department; (3) that the roentgenologist own his own equipment and collect the entire amount charged for the services of the x-ray department.

The first plan is the most objectionable to the roentgenologist but probably the most satisfactory to the hospital.

The percentage plan is fair to the hospital, if the roentgenologist does not demand too large a percentage. However, some roentgenologists feel that the hospital should not make a profit from the services of the roentgenologist or the x-ray department and that the percentage paid to the roentgenologist should be large enough to allow the hospital only the barest running expenses of the department. This is conducive to the waste of supplies and technicians' services, unless the roentgenologist has the best interest of the hospital at heart. However, from a business standpoint, if the percentage is fair it will stimulate the roentgenologist to strive for more work. . . .

The last plan, that of the roentgenologist's owning his own equipment, would create an intolerable situation in the hospital. It would be unfair to other men on the staff for the hospital to give to one roentgenologist a monopoly on the x-ray work of the institution, whereas that roentgenologist would not be an employee of the hospital. Also, the hospital would have difficulty in regulating his actions and charges, while at the same time the burden of collection for x-ray services would probably fall upon the hospital.

We have used, at different times in the past, all three of the above methods in this hospital. At the present time we are having the most satisfactory results by using the percentage plan.

FRANK J. WALTER,
Superintendent.

Denver, Colo.
St. Luke's Hospital.

Sirs:

The March issue of *The MODERN HOSPITAL* has so much of value to those of us who work in small hospitals. We are still hoping to remodel and enlarge our building. Our first plans were sent in December, 1933, and were rejected, because we did not have satisfactory means of repaying the loan. We had asked for \$110,000. The newest plans that have been submitted ask for \$50,000 and do not include any equipment. We shall depend upon local donations for that. . . . The architect had not planned a hospital for several years. Wish he had had the information that is in this issue. The article by Carl A. Erikson is very timely.

I was much interested in the article on "The Need for More Hospitals in Rural Areas." I enclose a rough map of Arkansas I made last year, showing the general hospitals. I had a large map made by a draftsman using this information and it was used at our Arkansas Hospital Association meeting in Little Rock. This shows four areas without hospitals in Arkansas, the largest and most densely populated one being to the north and west of Phillips County of which Helena is the county seat. . . .

ELLA M. SHAW,
Helena Hospital Association,
Helena, Ark.

Sirs:

. . . I was delighted to see the article in your last issue "Bulk Ether Warning." I am of the opinion that very few hospitals are equipped to take care of ether properly that is bought in large containers. It is my feeling that there are many ways of producing so much greater savings in a hospital without the dangers involved in such a practice. It is my feeling, however, that in the larger hospitals, where five-pound cans of ether can be used within a day or a day and a half, that the practice of buying it in five-pound containers would not present the problem as when it is bought in great bulk. . . .

GERTRUDE L. FIFE, President
National Association of Nurse Anesthetists,
Cleveland.

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PERSONALS

DR. CHRISMAN SCHERF, superintendent of Sea View Hospital, Staten Island, N. Y., has been transferred to Metropolitan Hospital, Welfare Island, New York City, and **DR. MORRIS JACOBS**, deputy superintendent at Metropolitan has been appointed acting superintendent at Sea View.

MRS. RAMONA BREESE has been appointed superintendent of Milford Emergency Hospital, Milford, Del. **MRS. WINONA BROWN**, who has been acting superintendent of the hospital for the past two years, will remain as Mrs. Breese's assistant.

WINIFRED MACSWAIN, active in dietetic work in San Francisco hospitals for many years and more recently a consultant to state tuberculosis hospitals, died in Berkeley, Calif. Miss MacSwain was the author of a booklet on tuberculosis diets which was used in hospitals throughout the state.

L. P. RAY, assistant superintendent of Crozer Home for Incurables and Homeopathic Hospital, Chester, Pa., has been made superintendent of Chester Hospital. He will fill the vacancy left by the resignation of **JOSEPH A. HULME** who has held the post for the past ten years.

MRS. ALMA HAM SCOTT has been appointed director at headquarters of the American Nurses' Association. Mrs. Scott has served as acting director since the resignation of **JANET GEISTER** in January, 1933.

DR. EDMUND A. CHRISTIAN has retired as active medical superintendent of the Pontiac State Hospital, Pontiac, Mich., but will remain at the hospital as advisory medical superintendent emeritus. **DR. P. V. WAGLEY**, for many years assistant superintendent of the hospital, has been named acting superintendent.

KATHERINE A. SANBORN, who recently retired as director of the school of nursing of St. Vincent's Hospital, New York City, has been honored by the alumnae of the school who have established a \$5,000 scholarship in her name.

DR. JABEZ N. JACKSON, director of health of Kansas City, Mo., since 1932, died March 18. Doctor Jackson, who was sixty-six years of age, served as a trustee and president of Kansas City

General Hospital and also had been consulting surgeon at that institution as well as at the Research Hospital and the Trinity Lutheran Hospital. He was president of the American Medical Association in 1927-28.

DR. EDWARD W. SCHWALL has been appointed superintendent of the Georgia Training School for Mental Defectives, Gracewood, Ga. He is succeeding **DR. JOHN ODEN**.

DR. WILLIAM DUANE, professor emeritus of bio-physics at Harvard University, died on March 7, as the result of a heart attack. Doctor Duane was famous for his researches in x-ray and radio activity. He worked with the Curies in their laboratory in Paris, and a few years ago developed an x-ray machine for treating cancer.

DR. REGINALD ATWATER, health commissioner of Cattaraugus County since 1928, recently resigned in order to accept the appointment of executive secretary of the American Health Association. He assumed the duties of his new office March 1.

HERBERT R. SANDS, a member of the staff of the United Hospital Fund of New York and of the committee on accounting of the American Hospital Association, died of heart disease on February 17, in Phoenix, Ariz., after an illness of three months. Mr. Sands is the author of "Accounting and Business Procedure for Hospitals."

JANNETT G. FLANAGAN has been appointed superintendent of the Children's Mercy Hospital, Kansas City, Mo., following the resignation of **ANNA A. ANDERSON**. Miss Flanagan was secretary of the Missouri State Board of Nurse Examiners at Jefferson City.

MRS. LUCIE FARQUHAR is the new superintendent of the Bedford Municipal Hospital, Bedford, Ohio, filling the position left vacant by the resignation of **LOLA MARGARET PHILLIPS**, who has taken a similar post at Titusville, Pa.

DR. GEORGE A. ZELLER has retired from the office of superintendent of Peoria State Hospital, Peoria, Ill. He will remain on the hospital staff with the title of superintendent emeritus, in recognition of his long term of service to the state and its hospital at Peoria.

DR. MARION R. KING of the Leavenworth Penitentiary staff has been appointed head of the U. S. Hospital for Defective Delinquents at Springfield, Mo. He succeeds **DR. L. M. ROGERS** who has been transferred to the Marine Hospital at Baltimore, Md.

DR. HARRY SAMUEL WAGNER, superintendent of the Barnstable County Sanatorium, Pocasset, Mass., died recently. Doctor Wagner had been superintendent of the hospital since 1919. He will be succeeded by **DR. JULIUS GODDARD KELLEY** of Rumford, R. I.

DR. M. L. HARRIS was made president emeritus of Henrotin Hospital, Chicago, at the first meeting of the board of trustees in the new hospital building.

JESSIE E. MACLEOD has been appointed superintendent of the Moses Taylor Hospital, Scranton, Pa. She is succeeding **JANET GORDON GRANT** who retired last January.

ANNA T. PASCHALL, formerly dietitian at Clifton Springs Sanitarium, Clifton Springs, N. Y., has been appointed dietitian of the Homeopathic Hospital, Wilmington, Del.

DR. ELMER I. MCKESSON, past president of the International Anesthetists' Society and inventor of gas anesthetic appliance machines that are used in hospitals all over the world, died in Toledo, Ohio, on February 22.

LEROY P. COX, assistant director of the Homeopathic Hospital of Rhode Island, Providence, R. I., has been appointed superintendent of Woonsocket Hospital, Woonsocket, R. I.

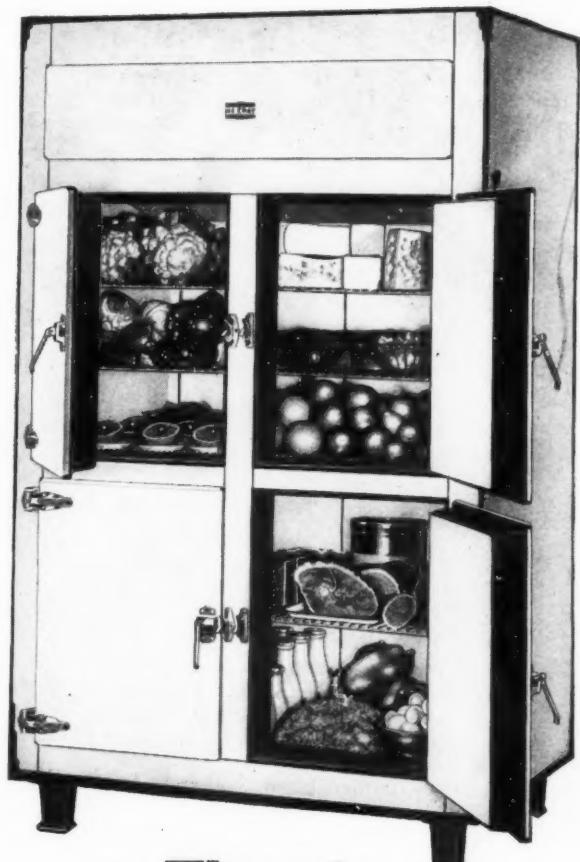
DR. PAUL KELLER, executive director of Newark Beth Israel Hospital, Newark, N. J., has resigned to engage in private practice.

DR. C. M. WILLIAMSON has been appointed superintendent of the Ponton-Brown Clinic Hospital, Edinburgh, Tex.

DR. EDWARD W. WHITNEY died recently after a few weeks' illness. Doctor Whitney was superintendent of the Northampton State Hospital for the Insane, Northampton, Mass.

LOUISE SMITH was appointed superintendent of the Bessemer General Hospital, Bessemer, Ala.

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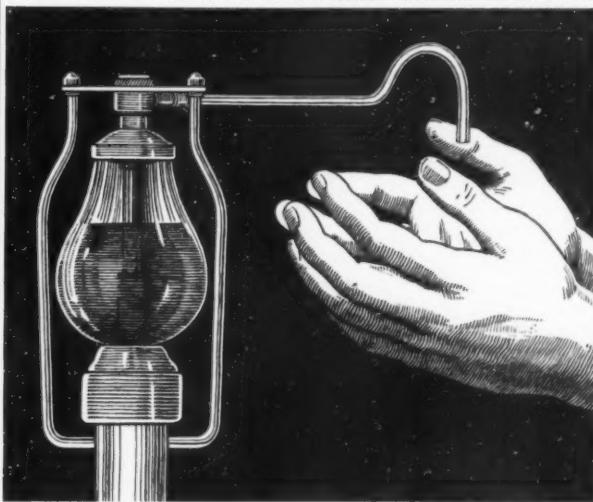
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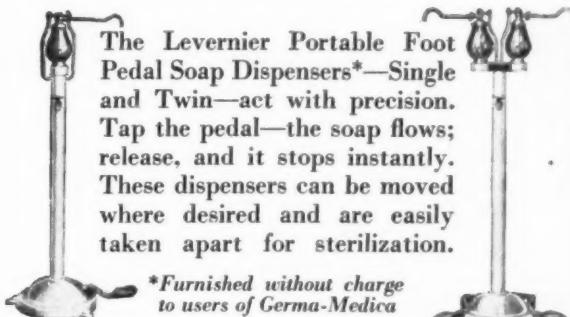
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ELsie LAWLER was awarded an honorary degree of master of arts by Johns Hopkins University, in recognition of her work as superintendent of nurses at Johns Hopkins Hospital for the past twenty-five years.

DR. HORACE ELWOOD BRAGDON, former head of the Chelsea Memorial Hospital, Boston, died at his home in Winthrop, Mass., after a long illness. Doctor Bragdon was obliged to withdraw from his hospital affiliation five years ago because of poor health.

DR. WINFORD SMITH, director of Johns Hopkins Hospital, Baltimore, has been appointed chairman of the advisory committee of the newly created department of public welfare of that city.

FLORA J. SMITH has been named superintendent of the Jay County Hospital, Portland, Ind., to succeed HELEN L. WILBUR.

NORA MAE HUTTO of the William H. Coleman Hospital for Women, Indianapolis, will succeed NOAILES HAYES as superintendent of the William S. Major Memorial Hospital, Shelbyville, Indiana.

DR. HORACE DAVID ARNOLD, former dean of the Harvard Graduate School of Medicine, died at his home in Waltham, Mass., at the age of seventy-two. Doctor Arnold was formerly president of the national board of medical examiners and assistant superintendent at Boston City Hospital. He also has been on the staff of Tufts Medical School.

DR. L. ARTHUR LESSARD, former superintendent of the Notre Dame Hospital, Montreal, Que., has recently been

appointed special officer of the department of public assistance of the Province of Quebec.

DR. D. C. COLES, medical health officer for Regina, Sask., is acting superintendent of the Regina General Hospital until a permanent administrator is brought in to take the place left vacant by DR. H. H. MITCHELL.

HARRIETT S. HARTRY, superintendent of St. Barnabas Hospital, Minneapolis, for many years, resigned recently and went to Florida for a short rest. Her successor has not yet been named.

FATHER JOHN J. HEALY, president of the Arkansas Hospital Association, was recently elevated to the rank of "Monsignor."

KATHERINE B. STOTT, Ingalls Memorial Hospital, Harvey, Ill., has been appointed superintendent of the Good Samaritan Hospital, Phoenix, Ariz., to fill the vacancy made by the resignation of MRS. J. O. SEXSON.

LIZZIE WIEBE, superintendent, Schlitz Memorial Hospital, American Falls, Idaho, died recently. Miss Wiebe had been associated with the institution for many years.

VIRGINIA SUTPHIN was elected superintendent of Charles Town General Hospital, Charles Town, W. Va., following the resignation of MISS M. P. DALE.

FRED M. LONG will become superintendent of Bellevue Home for the Poor, Washington County, Maryland, on April 1, following the resignation of WALTER WOLFE who has been head of the institution for eleven years.

MANDEL R. ABRAHAMS, superintendent, Ideal Hospital, Endicott, N. Y., has resigned from the superintendency of the hospital, effective April 1. The president of the board of managers has also resigned. **PEARL ELDRIDGE**, night supervisor, has been named acting superintendent of this city owned institution. Mr. Abrahams was appointed superintendent last September succeeding **ELOISE QUICK**.

THEODORA H. LE FEBVRE, well known throughout the country as a leader in the nursing profession, died at the City Hospital School of Nursing at Welfare Island, New York, of which she was formerly principal. Miss Le Febvre was also at one time superintendent of the school of nursing at the Binghamton Hospital, Binghamton, N. Y., as well as at the Mount Vernon Hospital, Mount Vernon, N. Y., St. Joseph's Hospital, Yonkers, N. Y., and the Toledo Hospital, Toledo, Ohio, and in addition to her hospital duties served as secretary of the New York League for Nursing Education.

MRS. MILDRED LENOIR has been appointed the new superintendent of the Eugene General Hospital, Eugene, Ore.

MRS. EMMA PURSLEY, R.N., is the new superintendent of the Wahpeton Hospital, Wahpeton, N. D.

DR. LEONARD A. WEST has been appointed medical examiner for the bureau of air commerce in Des Moines, Ia. Doctor West was flight surgeon in the medical reserve corps.

SARAH A. DENVER, superintendent of St. Mary's Hospital, Leonardtown, Md., has resumed her duties at the hospital after an extended vacation.

McLeod Infirmary Moves Into Modern Quarters

Twenty-nine years ago in Florence, S. C., Dr. Frank Hilton McLeod opened an infirmary in a frame residence so built that it might accommodate eight patients. On February 20, the McLeod Infirmary, a hospital plant representing an investment of three quarters of a million dollars formally opened its new addition.

The infirmary, a community hospital under the direction of the Duke Foundation, has been moved into the modern seven-story, \$350,000 building, and the old brick structure which formerly housed the hospital is to be used as a home for nurses.

Over eight thousand people inspected the new building on the day of its formal opening. Doctor McLeod is superintendent of the hospital, and his son, Dr. James McLeod is assistant superintendent. The new building has forty ward beds more than the old, and many more accommodations for Negro patients. It was financed by a PWA loan.

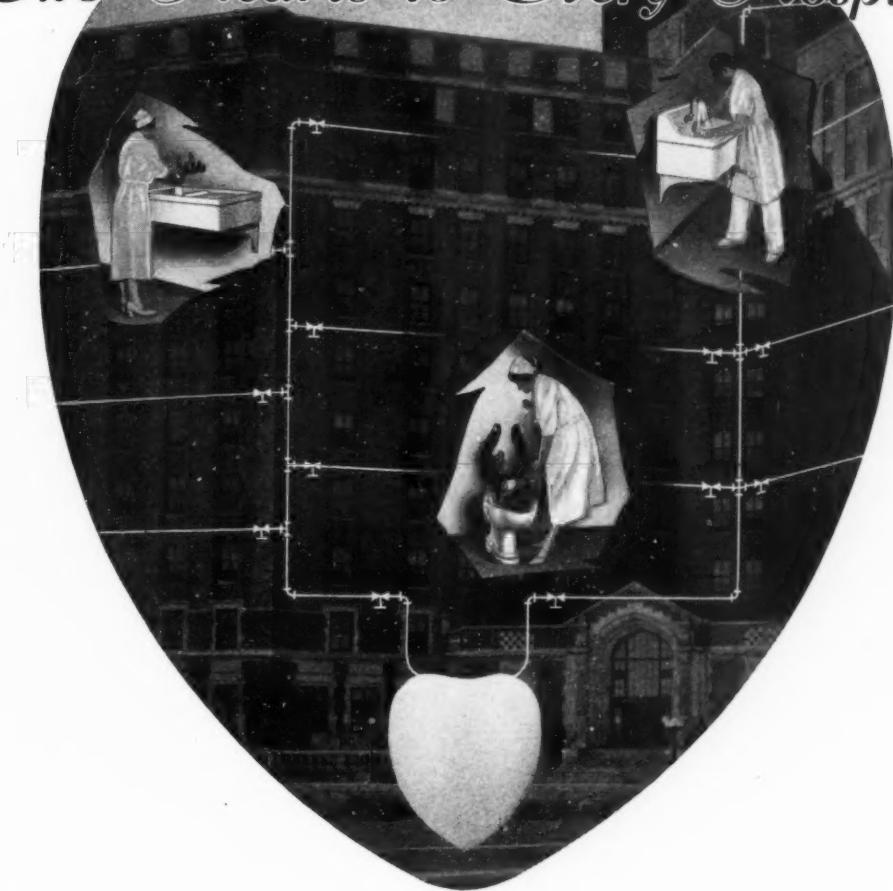
Sales Tax Refund for Hospitals

An amendment to the sales tax before the Arkansas legislature at present gives hospitals the same status as state or federal institutions by a monthly refund of taxes paid upon the certification of the superintendent.

PWA Projects Announced

Work has begun on three hospital projects financed by the PWA at a total cost of \$1,009,000. The Dermott City Hospital, Dermott, Ark., is carrying out its plans at a cost of \$85,500; the Franklin Square Hospital, Baltimore, will use the \$715,000 loan for the construction of a maternity unit, the installation of a central laundry and the renovation of the heating system; the University of Virginia Hospital, Charlottesville, Va., is building a \$208,500 addition which will contain forty private rooms, a new delivery room, a nursery, some offices and a small department equipped for physiotherapy and hydrotherapy.

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Hospital Literature in Abstract

Conducted by E. M. BLUESTONE, M.D., Montefiore Hospital, New York City

Sterilizing With Steam

Steam is the principal agent used for the destruction of bacteria and spores. Steam used in sterilization is commonly known as saturated steam as it contains a percentage of moisture.*

The following pressures and corresponding temperatures are taken from current steam charts:

Pounds Pressure	Degrees Fahrenheit
5	227
10	240
15	250
20	259
25	267
30	274

The temperature necessary for successful sterilization is 259-267 degrees which is equal to 20-25 pounds pressure for a sufficient period of time to allow penetration to the center of material.

All air must be purged from the sterilizer, as air trapped in it will reduce the temperature considerably and cause improper sterilization.

A well designed steam return piping and a properly designed sterilizer should eliminate trouble from the trapping of air. The steam furnished must be clean, as impurities, such as oil, will have a tendency to clog sensitive parts, like reducing valves, and dry on the metal of chamber or pipes, acting as an insulator.

Where generators are used to produce steam, they should be cleaned periodically as water supplied by our city mains or wells contains impurities which will retard sterilization.

The waste line to the main plumbing must be connected so that no contamination can occur through a back-up of sewage or gases from the sewerage system.

Gauges of sterilizers should be tested for accuracy from time to time.

Air is trapped in the sterilizer when steam condenses and creates a vacuum which draws the air through the valves. If this air is not released, the temperature is kept down, regardless of the pressure, because the air acts as an insulator in the area where it is

trapped, thereby cutting down the heating surface according to the size of the area.

A thermometer should be placed in the center of material to be sterilized so as to ascertain whether or not the proper degree of temperature has penetrated to the center of materials being sterilized.

*Underwood, Weeden B.: Scientific Analysis of Steam as Used in Sterilizing, Bull. Am. Coll. of Sur. 18: Dec. 1934. Abstracted by W. J. Overton.

When to Awaken Patients

Further progress has been reported by the voluntary hospitals of London on the inquiry held under the auspices of King Edward's Hospital Fund in England about the waking hour in the hospital.* "Unless there was some exceptional and adequate reason to the contrary, the most suitable hour for the waking of patients is six o'clock," the Fund recommended in 1931.

At the time of the original inquiry, the waking hour was earlier than six o'clock in more than half of the London hospitals. Within a year the number had fallen to one-third, and the latest report says that it has been reduced to one-fifth.

If the calculation is based on the total number of patients, the results are even more satisfactory, only one-seventh of them being awakened now earlier than six o'clock. According to the report, the hospitals in the minority have some special reason which is checked up by the officers of the Fund during their annual inspections.

*Brit. M. J. No. 5,856, p. 1009, 1934. Abstracted by Dr. E. M. Bluestone.

Causes of Illness and Death Compared

Collins* has continued the analysis of morbidity in a general population group based on the data collected by the Committee on the Costs of Medical Care. These data are arranged by age groups and compared with similarly

arranged data on the causes of death. It is obvious from these comparisons that the major causes of death are not the most frequent causes of illness. The respiratory diseases are outstanding as causes of both disabling and non-disabling illness but occupy a much less significant place in mortality. The degenerative diseases are more important as causes of death. The highest illness rates are in infancy and early childhood; the highest death rates in old age. Illness is least frequent from 15 to 19 years of age and death is least frequent from 10 to 14. Death rates vary with age far more than illness rates.

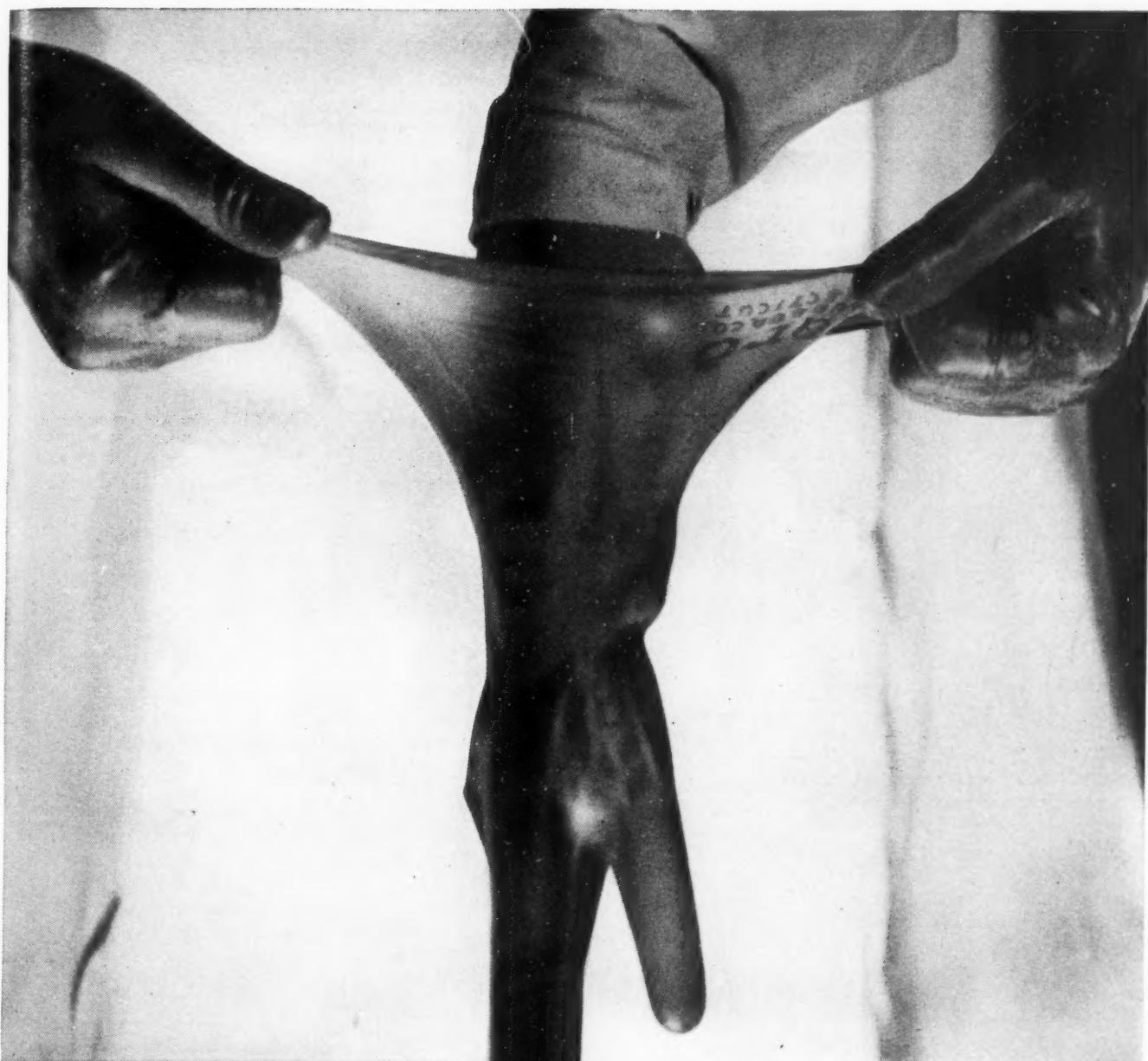
*Collins, Selwyn D.: A General View of the Causes of Illness and Death at Specific Ages, Based on Records for 9,000 Families in 18 States Visited Periodically for 12 Months, 1928-31, Public Health Reports, Feb. 22, 1935. Abstracted by Alden B. Mills.

Foreign Catgut Found Nonsterile

This investigation* is a continuation of a previous paper in which the author reported results of bacteriologic examinations of several thousand catgut sutures which had been sterilized chemically. These were practically all of American manufacture. He found that "chemical sterilization" was a fallacy and emphasized the reliability and uniformity of carefully controlled heat sterilization.

The author now tests various foreign brands of catgut. A total of 1,204 sutures comprising 101 lots from twenty-four brands were examined chemically and bacteriologically. The brands included eight British, four French, six German, two Japanese and four Spanish. Most of the brands contained a mercury compound, and a few iron, copper or iodine. Of the twenty-four brands examined, fifteen (62.5 per cent) were found to be non-sterile.

The organisms grown on culture comprised Gram negative and Gram positive nonsporulating aerobes; Gram positive sporulating anaerobes with subterminal spores and gas formation.



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ically fashioned that they allow utmost finger freedom. They fit like skin and never bind or cramp—never resist the delicate movements of the skilled hand.

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their acceptance, make Seamless Standard Surgeons' Gloves a shrewd investment. One hospital wrote us, "Out of many brands used, your gloves hold up the best." But see for yourself. Try them for six months.



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From the labels the author could not tell accurately whether heat sterilization had been used or not but most of the brands that proved to be sterile possessed certain physical properties characteristic of catgut that has been sterilized by heat.

The examination of foreign brands of catgut substantiates the conclusions drawn from the previous examination of American brands, namely, (1) The so-called chemical sterilization of surgical catgut by any method yet devised is inefficient and unreliable. (2) Carefully controlled heat sterilization is the only uniformly reliable and positive method of sterilizing surgical catgut sutures.

*Clock, Dr. Ralph Oakley: The Sterility of Surgical Catgut Sutures, With Particular Reference to Foreign Made Catgut. *Surg. Gyn. and Ob.* 59: 899-903, 1934. Abstracted by Arthur H. Aufses, M.D.

Broadening the Scope of the Hospital

The trends of social and economic policy in this depression era are outlined by a hospital administrator, who would have the hospital do something rather than accept federal action.*

The rise of the hospital as the community health center is a significant trend in social policy. The relationship of the public to the hospital has long awaited adequate definition and the humanizing of the hospital is the keystone of this relationship. The place of the patient in the life of the hospital is supreme. After the early days when the patient was not a prime mover came the day of reckoning when the lowly "case" became a human being, the focal point in the scheme of the institution. The author goes so far as to advocate a personal survey of the patient by nurse and dietitian which would reduce individualized care almost to an absurdity when employees report a patient's every whim to the administrator.

And this change has left its imprint on the cost system. Economic necessity is leading institutions to group action and the hospital is adjusting to group consciousness but since the author is merely pointing out trends he does not wish to commit himself on the probable outcome of this adjustment, such as state medicine.

On the necessity of a sound financial program for hospitals the author takes a decided stand. Sound business methods, especially as embodied in cost accounting is the *sine qua non* for the "forgotten institution," as he terms

the voluntary hospital. It cannot look to the Santa Claus on the Potomac, but must persuade the community to assume its obligation. This it can do only if it has a well ordered household.

But, at the same time that the author pleads for community support, for taking the public in as a partner, for strengthening friendly relationships, he contradictorily promotes, as one of his economies, the cessation of so much gratuitous service by the hospital. He would have nurses charged for their training, the employees of a hospital denied professional courtesy, and the hospital in general so cold an institution that the public might confuse it with a bank. He is on much more logical ground when he urges protection for the hospital in compensation cases and insurance cases, when the patient is paid but the hospital cannot collect its bill.

The article makes a good point of the lesson learned during these lean years, namely, that the hospital can exist as well on many small contributions as on a few large gifts, and that since large gifts are not now forthcoming, the democratizing of philanthropy is a means for the continued existence of the hospital as well as for the broadening of its influence in the community.

*Hanner, G.: Some Trends in Hospitalization, *Col. Med.* 32: 52-62, Jan. 1935. Abstracted by S. S. Kauvar, M.D.

The Dressing Sterilizer From a Nontechnical Standpoint

This article* discusses the anatomy and pathology of the dressing sterilizer from a practical and nontechnical standpoint, and indicates their importance in maintaining the rigid asepsis that surgery requires.

Morphologically the sterilizer consists of steam jacket and sterilizing chamber, with three distinct service lines. The first, the steam supply line, together with its strainer and control valve, needs periodic inspection and must be capable of easy replacement. The second, the steam return line with its steam trap and check valve, must be kept clean and free of obstruction. The third, another discharge line, with construction similar to the steam return line, must be installed to blow free to the open air, and should have a screen near the point where it leaves the sterilizing chamber.

This device combined with proper preparation of packs of dressings, ensures necessary penetration because it

provides that the gauge reading will be equivalent to a definite temperature and not be a combined reading of steam and air pressure. Every precaution must also be taken to maintain the free and proper functioning of the pop valve.

A water gauge glass sterilizing device which effectively sterilizes the water gauge glass and its contents also obviates the hazard of contaminated air entering from the outside to break up the vacuum formed when the sterilizer cools or water is withdrawn. It is thus possible to be sure of obtaining moist heat of 255° F. by operating sterilizers under 18 pounds pressure for thirty minutes, which kills resistant pathogenic bacteria and gives a wide margin of safety over the experimental requirements. No mention is made of acceptable devices for inclusion in the center of packs to check the attainment of desired temperature.

*Wyatt, H. T.: The Fundamental Principles Underlying the Mechanics and Technique of Sterilization, *Bull. Am. Coll. Sur.* 18: Dec. 1934. Abstracted by S. S. Kauvar, M.D.

How to Simplify Record Keeping

In order to obtain a statistical picture of the methods employed in the filing and indexing of patients' records, together with the nomenclature used, questionnaires were sent out to 1,899 hospitals with a capacity of 100 beds or over. Approximately 50 per cent of the questionnaires were returned.*

The replies revealed that the most essential element in a cross indexing plan is a card file to facilitate the location of the patient's record, and this is best accomplished by the assignment of an identity number for the individual patient. At the present time this method prevails in about one-third of the institutions answering the questionnaire. The unit system of filing should be employed, thus uniting all the readmissions of the same patient.

At the present time about one-third of the larger institutions do not follow this system of filing. A large percentage still file each admission separately, which necessitates the assembling of all records each time the patient is readmitted. A small percentage of institutions, mainly those dealing with mental cases, still bind the records of one patient to those of another in book form.

About 44 per cent of all institutions follow no definite plan of nomencla-

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ture whatsoever, 6 per cent of the institutions use the Standard Classified Nomenclature of Disease in addition to their own nomenclature (while introducing the standard nomenclature) and 25 per cent are considering the adoption of the standard nomenclature. Thirty-four per cent use such systems as the Massachusetts General, Ponton or Bellevue.

To check this analysis, a corresponding study was made of all hospitals in Minnesota, those of less than 100 beds as well as larger hospitals. It showed that, while the prevailing method of filing and cross indexing is not encouraging in the larger hospitals, the picture would have been much worse if the questionnaires had also been sent to small hospitals.

In general, the larger institutions were found to be much better organized in the matter of identity numbers, unit record systems and cross indexing.

Included in the report is a list of institutions possessing special indexing equipment for the benefit of any hospital administrator who might wish to install some type of mechanical index system.

*Dunn, Dr. H. L., and Dunn, Dr. H. B.: A Statistical Survey of the Methods of Cross Indexing and Filing of Medical Records in Hospitals of 100 Beds or Larger. *Jour.-Lancet*, Jan. 1, 1935. Abstracted by Lillian B. Wiener.

Doctor or Layman for Hospital Superintendent?

The Incorporated Association of Hospital Officers discussed the question, "Should the Chief Administrator of a Hospital Be a Layman?" during the recent public health congress in England.*

Major Jackson thought that the evidence was in favor of the layman on the ground that his whole life could be lived in the sphere of administration. "A good doctor," he said, "could not as successfully be anything else. Administration calls increasingly for its own special training." He did not think that a doctor could interest himself under ordinary circumstances in money raising activities, the purchase of supplies, the construction of buildings and their equipment. It was not necessary, he felt, to train an administrator in medicine and surgery when the greater part of his time would be spent in administrative details. He admitted, however, that the gift of administration was inborn and while it was likely to be found among physicians, it was more likely to be found among laymen.

Major Dryland, speaking for the mental hospitals, argued that the chief direction should undoubtedly be medical. Where a doctor became a good administrator, the medical flame burned less brightly. While the chief authority should be medical, he thought that the medical administrator should be relieved of all administration that a competent layman could undertake.

Mr. Metivier gave reasons why the responsible administration should be divided among three people: the doctor, the lay administrator, and the matron.

Mr. Leaney said that the administrator was a coordinator of many departments. Medical men had managed to discipline themselves in the past, but they were under terrible temptations today and there should be someone in control of medical as well as lay hospital workers.

Mr. Healey argued that there should be one supreme head who must be medical, but the lay administrator should have a clearly defined scope and status. Mr. Steventon gave examples of profound lack of business knowledge in first-class medical men.

Doctor Goode said that in dealing with the medical question there must be a medical man. It was easier for a medical man to discuss matters of administration with other medical men.

Doctor Eason (our Doctor Eason) described himself as a mule addressing an audience of horses and asses as to which was the better parent. No one man, he said, could do all of the work of an administrator in a large institution. A wide medical knowledge and active practice prevent an executive from becoming narrowminded. He pointed out that the medical profession was characterized by intense individualism, which is the breath of life to medicine. A medical administrator could act as a successful go-between in matters of policy, extravagance, punctuality and so on. No administrator could run a hospital. He must have a team. He felt that there could be no positive or final answer to the question under discussion.

Mr. Orde, honorary secretary of the British Hospitals Association, said that he, as a layman, found no difficulty in dealing with matters administrative if he went about it the right way. He didn't think that the terms "layman" and "doctor" had any relevance. A hospital, he said, is a hotel for the sick, which requires just as much management. "There is danger when a man possesses qualifications that are not in constant use; they cause a bias, and if

there was one man on God's earth who needs to be free from bias it is the hospital administrator."

Dr. Caroline Maude argued for two heads, with the medical director having the final word.

**Lancet*: 2: 1241, 1934. Abstracted by E. M. Bluestone, M.D.

Sterilizing Dressings

The authors have compared the sterilizer chart temperatures with the actual temperatures inside the drums and bundles being sterilized.* Observations were made at five-minute intervals beginning at the time the chart reached the sterilizing level. In 686 observations they found that all intra-bundle and intra-drum temperatures did not reach the sterilizing temperature level until 30 minutes after the sterilizer chart had registered that level. In other words, contents of drums sterilized for 60 minutes were actually only subjected to the minimum required temperature for 30 minutes.

Temperatures taken of solutions showed that after 15 minutes of sterilization all of the solutions had still not reached the minimum temperature required. Nevertheless, bacteriologic cultures of these solutions were negative in all cases.

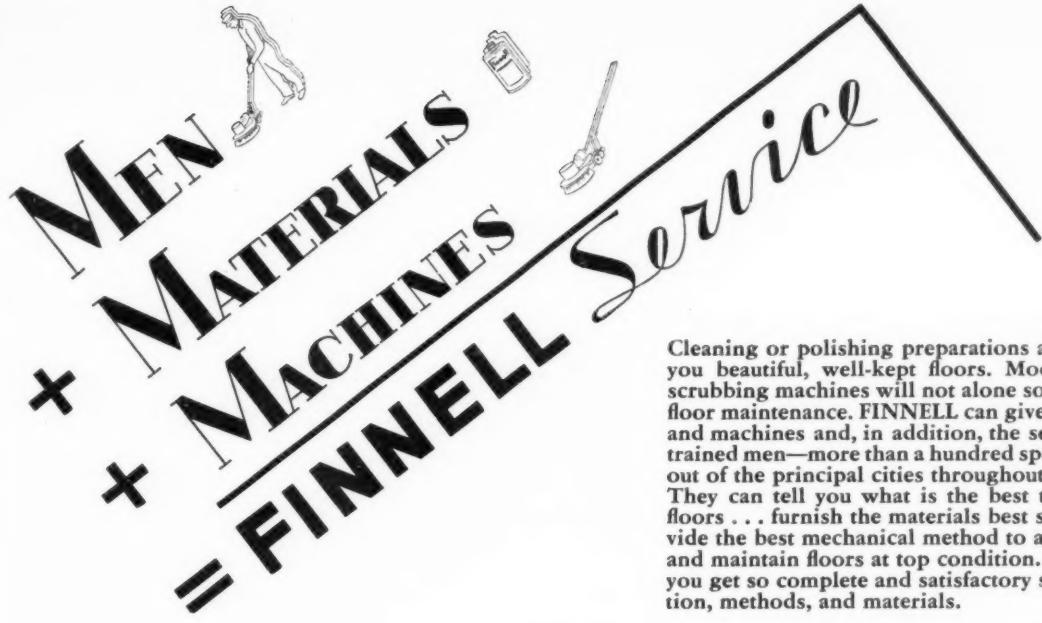
Temperatures taken within bundles of heavy linen gave approximately the same results as those taken within drums. It required 25 minutes at sterilizer chart minimum level before intra-bundle readings universally reached the sterilizing level.

Temperature within gloves in all cases reached the minimum level after 15 minutes of sterilization.

A total of 616 bacteriologic studies were made. Nine cultures were reported positive, *Staphylococcus aureus*, *Staphylococcus albus* and Gram negative bacillus. All of these were in articles sterilized more than 10 minutes and since no organisms were found in any cultures done on articles sterilized less than 10 minutes the positive cultures were felt to be due to laboratory contaminations.

Conclusions drawn are that time is required for the intra-bundle and intra-drum temperatures to reach the sterilizer chart temperature and that there is a definite irregularity of steam penetration of different materials.

*Hewitt, S. R. D., and Balding, Lyla C.: Observations on Sterilization of Dressings With Specific Reference to Sterilizing Chamber Temperatures and Their Relation to Sterilizer Chart Temperatures and Cultures, *Bull. Am. Coll. Sur.* 18: 36, Dec. 1934. Abstracted by Dr. Arthur H. Aufses.



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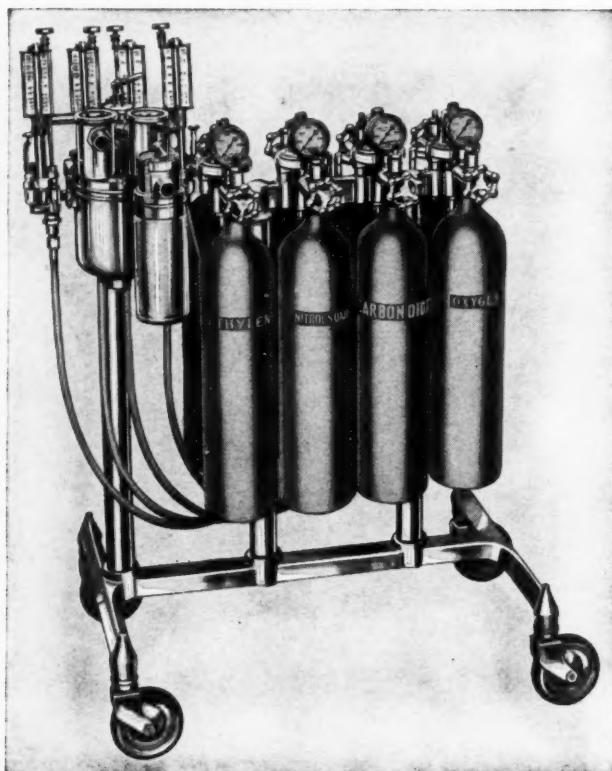
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BOOKS ON REVIEW

TREATMENT BY DIET. By Clifford J. Barborka, M.D. Philadelphia: J. B. Lippincott Company, 1934. Pp. 615. Illustrated. \$5.

Doctor Barborka has struck a new note in this book, one that promises to be much appreciated. The greater part of the subject matter is in tabulated form and it is surprising how much information is given concisely and completely by this system of procedure. For example, with the superabundance of printed matter being issued today on the subject of vitamins we find here every item of significance about these food elements condensed into a table of one page for each vitamin.

Other nutritive elements are summarized in brief paragraphs followed by a short discussion of calories for energy requirement. In conjunction with these are a list and analysis of foods that serve as a basis to meet the requirements for all diets and for typical diets. A few substitutes for commonly used foods are given.

In Part 2, "The Application of Dietotherapy," qualitative and quantitative diets and the distinction between them are made clear. Methods of calculation are outlined and comparative servings of the several groups of foodstuffs are illustrated by pictures and by lists of typical foods, with their gram weights and household measures.

Part 3, "Diet in Disease," is separated into (a) the diseases in which the diet is of paramount importance, and (b) conditions in which diet is of varying importance.

Part 4 is devoted to hospital diets, classified as nonresidue, liquid, semi-solid, soft, light or bland, general.

In an appendix are numerous tables, some of which are not found in the usual books on dietetics. A lengthy bibliography adds further value to the book.

Acknowledgment is given to the author's dietitian, Pearl Lewis, for her "aid and criticism."—LULU G. GRAVES.

A TEXTBOOK OF NURSING TECHNIQUE. By Marion L. Vannier and Barbara A. Thompson. Second edition, revised. Minneapolis: University of Minnesota Press, 1935. \$2.50.

The fact that a second edition is published within four years from the time this book was first put into use shows that this manual of nursing procedures is meeting a need of the nursing service in many hospitals.

Originally the manual was designed for the use of students in the University of Minnesota school of nursing. This school, sending its students to four general hospitals both public and private for practical ward experience, found it desirable to develop a uniform method of nursing procedures suitable for all types of patients.

The book deals with practical procedures only. It does not attempt to present either the application of the basic sciences or the fundamental principles underlying good nursing. The authors recommend that it be used along with a more exhaustive text.

The contents are in outline form, arranged under such headings as purpose, articles needed, preparation of patient, preparation of equipment, procedure, after care of patient, after care of articles, references. The instructions are both clear and concise.

It seems to me that the book might be helpful to two groups, first, students who have difficulty in condensing material into outline form, and, second, hospitals that maintain a graduate nursing staff representing many schools.—ADA BELLE McCLEERY, R.N.



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NEWS FROM MANUFACTURERS

Travels With a New Food Cart

If the dietitian wants to play her best card with special diet patients who dislike reheated food, she may utilize the "Ideal" Special Diet-veyor recently produced by The Swartzbaugh Mfg. Co., Toledo, Ohio.

This conveyor, equipped with two top deck compartments, two drawers and four sections holding trays into which Hall china cups are fitted, emerges from the kitchen with savory food that stays hot until it meets the discriminating eye of the patient. Up to forty six-ounce servings may be distributed by one attendant to different points. The china cups, with stainless steel covers, are tagged with the individual patient's name.

Safety Sides That Fit Any Bed

Patients may yield to the wanderlust urge, consciously or unconsciously. Some of them may be afflicted with a tendency to fall out of bed. To prevent this vagrancy or bruising response to the law of gravity, the Inland Bed Company, 3921 South Michigan Avenue, Chicago, offers the acceptable and novel idea of removable safety sides for beds.

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use by the patient in need of protection. They are trustworthy substitutes for the nurse or other attendant who must otherwise be vigilantly on guard. Further, an adroitness in design eliminates the formidable appearance of sides sometimes used for this purpose and the patient does not appear so restrained, it is stated. They are practically indestructible, we are told, are inexpensive, may be purchased in a number of sanitary and durable finishes, and are lined so they will not mar the surface of the bed to which they are clamped.

Putting Pipe in Its Place

Those who want to put the right pipe in the right place would do well to write the newly created Commercial Research Department of The Reading Iron Company, 401 North Broad Street, Philadelphia. In establishing this service, the company recognizes that many conflicting claims have been made for different kinds of pipe and that the resulting confusion has been detrimental to the interests of the pipe buyer. Skilled technicians will give disinterested information, without charge, regarding the relative merits of various makes of pipe according to the company's announcement. They will offer conclusions based on conditions of service and on the actual service records of certain kinds of pipe under those conditions.



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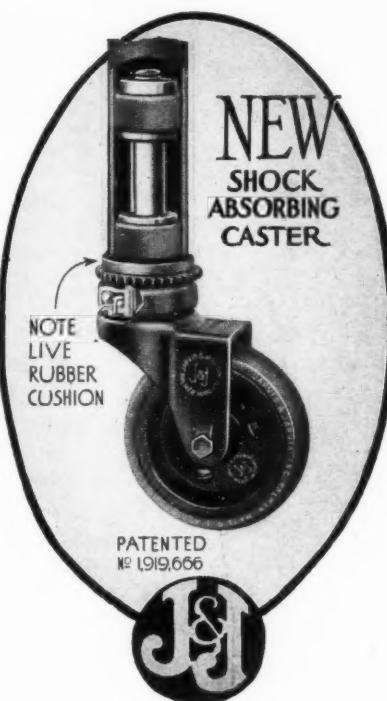
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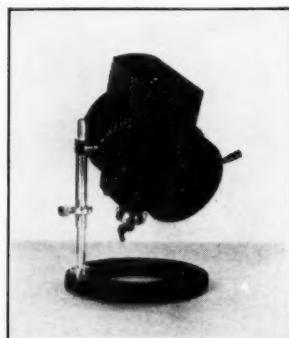
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The Nursery Votes Approval

Baby patients have a bone to pick with grown-ups who offer them indigestible food combinations. But now, according to Libby, McNeill & Libby, Chicago, an infant's good digestion waits on his appetite with various homogenized foods recently developed.

In the process of homogenization, vegetables, fruit, cereals and soup are made as smooth as milk, it is said, without removing the bulk necessary to the infant's diet. Harmfully rough cellulose and coarse fibers of solid foods are broken down so that delicate digestive tracts are not irritated, and rapid and complete digestion helps to reduce the incidence of intestinal upsets. These readily assimilated foods, states the manufacturer, are not single foods. They are formulated combinations, balanced to include the minerals and vitamins needed in the infant's daily diet.

An Economical and Quiet Fan

The Master-Aire, a fan of new design, has been announced recently by Westinghouse Electric and Manufacturing Company, Mansfield, Ohio. The fact that the manufacturer has designed this fan to operate quietly and economically makes it of particular interest to all hospitals.

This new fan is built in twelve-inch and sixteen-inch sizes and embodies an economical capacitor type motor. The Master-Aire uses from 23.5 to 25.4 per cent less electricity than conventional fans of similar size, and the capacitor motor brings the fan up to full speed 50 per cent faster than the ordinary types, according to the manufacturer.

The efficiency of the Master-Aire, it is said, is due to the application of the capacitor or condenser. This part is really a section of the motor mounted in the fan base, below the switch. It produces an even flow of current and reduces the hum, assuring quieter operation, it is pointed out.

With the transformer as well as the capacitor mounted in the fan base the center of gravity is low, which tends to make the fan stable.

In addition to the new motor design these fans have newly designed, electrically welded guards with graceful lines and heavier construction. The Master-Aire fans also use the Westinghouse patented, fully enclosed, oscillating mechanism and quiet, rustproof, warpproof, Micarta blades.

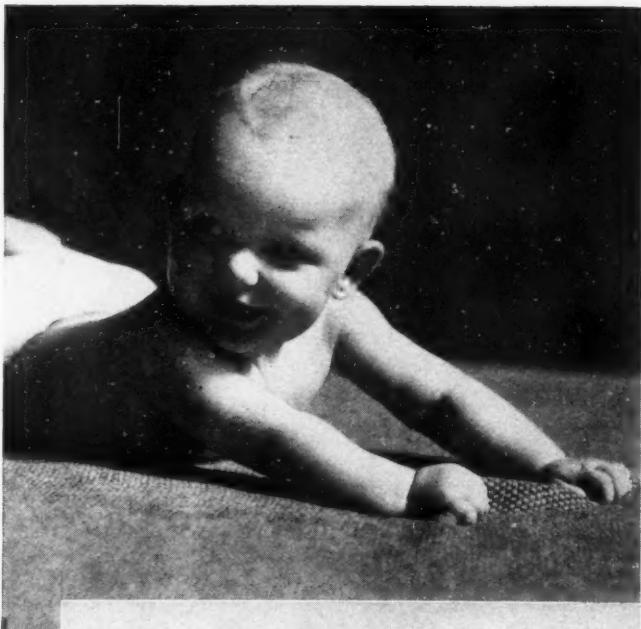
Tenderizing Device Cuts Meat Costs

A scientifically designed device for severing into short pieces the tough, sinewy fibers that are present in low cost meats is announced by Kellogg and Tree, 300 Madison Avenue, New York City.

The Tenderette is exceedingly simple to use. The meat is placed on the round turntable of the machine and the handle, which carries the tenderizing blades, is pressed down, thereby forcing the blades into the meat. The handle is then repeatedly swung over the entire surface of the meat so as to cut the fibers from various angles.

This severing process does not break the juice pockets or force the juices from the meat, it is claimed. All of the less expensive cuts of beef, pork and veal may thus be tenderized.

The manufacturer gives the following as an example of the savings possible with this machine: "A sirloin steak will cost, on the average, \$0.28 a pound. A chuck steak that can be tenderized will cost only \$0.15 a pound, resulting in a saving of \$0.13 a pound, or 46 per cent."



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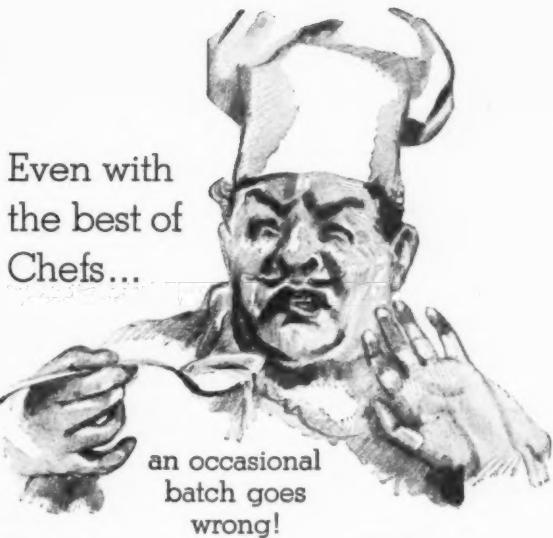


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A Light Weight Steam Trap

A combination float thermostatic trap has been added to the line of steam traps manufactured by Sarco Co., Inc., New York City.

The trap is compact in design and light in weight and can be supported directly on the piping, according to the manufacturer. The inlet and the outlet are on the same side, a small vertical distance apart for easy connection to horizontal pipes. The working pressure of the trap is given as 180 pounds per square inch.

All working parts are on the cover and can be exposed for cleaning by removing the trap body and without disturbing the connections. The automatic air by-pass is arranged on the down board side of the trap, so that the thermostatic element is at no time exposed to the full steam pressure. This arrangement, it is claimed, prevents the trap from becoming airbound.

New Trade Catalogues and Pamphlets

The Intricacies of a Water Still—We go on an imaginary excursion through a water still by studying a new bulletin issued by Barnstead Still and Sterilizer Co., Inc., 31 Lanesville Terrace, Forest Hills, Boston. Columns of description of "How a Barnstead Still Operates" accompany a large cross section illustration of a water still. Of single, double and triple types, these stills will furnish from one-half gallon to 5,000 gallons distilled water per day and they may be heated by steam, gas or electricity. The bulletin presents further information on how this water still meets exacting requirements in specific laboratory and routine hospital work.

Lines Drawn With Fences—Define your property lines with fences, advises The Stewart Iron Works Co., Inc., Cincinnati, in a new catalogue which includes several pages devoted to enclosures suited to hospital grounds. Fences promote privacy and discourage trespassing, it is stated, but decorative fences and gates also serve as a kind of frame for the landscape scene. Also illustrated are lawn furniture, vases, urns, bird baths and other specialties for dressing up the institutional grounds.

Calling the Roll With Record Forms—The widely diversified series of charts, records and other forms shown in catalogues just received from Hospital Standard Publishing Co., 40 South Paca Street, Baltimore, suggests that no symptom in a diagnosis and no statistic in the hospital is so trivial that it can escape being securely pigeonholed and recorded. It is stated that, in addition to the variety of standardized types of records, miscellaneous or special forms may be produced according to specification.

Two-In-One Fan—The happy combination of fan and lighting fixture in one unit produced by Edwin F. Guth Company, St. Louis, has undergone significant improvements according to a recently issued catalogue. The Guth-fan Conditionaire draws the cool air from the floor and distributes it in an even flow over a wide area, leaving the hot air near the ceiling undisturbed. Beauty and style as well as utility are characteristics of this fixture and the new designs will harmonize with the plainest or most luxurious surroundings, states the manufacturer.

Diets and Dainties—Appeal to the eye as well as to the palate is featured in the recipes set forth in the attractive set of booklets recently received from The Knox Gelatine Laboratories, Johnstown, N. Y. Included in the series are recipes for dishes suited to the special dietary requirements of convalescents, diabetic patients, children and even those whose principal ailment is obesity.